MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1860)

CERTIFICATE OF DEATH

Reg. Diat. No. 10755

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville 28, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years, 5 months

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 3 years, 5 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: —

City or town: Baltimore, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6604 Glen Oak Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: --

3.(a) FULL NAME: Clara B. Albrecht

3.(b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: George A. Albrecht

6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): August 27, 1868

8. AGE: Years	Months	Days	If less than one day
77	2	14	... hrs. ... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: home

FATHER
12. Name: ? Riegel
13. Birthplace: Maryland

MOTHER
14. Maiden name: ?
15. Birthplace: Maryland

16. Informant: Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/14/45 (month) (day) (year)

Cemetery or crematory: Holy Redeemer Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 11/12 19 45 (Date rec'd by registrar) A. M. Ulrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/11 19 45, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sev. only 11-11-45, to ... 19...; and that I last saw her alive on 11-11 19 45.

Immediate cause of death	DURATION
Bronchial Pneumonia	2 days
Fractured Rt. Femur	50 days
Due to: Accidental fall — fell out of bed. Sev. S.	
Due to:	
Other conditions: Arteriosclerosis	3 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of September 21st, 1945.

Where did injury occur? Catonsville (City or town), Co. Baltimore (County), Maryland (State)

Injured at home, farm, industry, public place (where?) Spring Grove Hospital

Means of injury: Injured at work?

23. SIGNATURE: M.D. A. D. Caplan, M.D. M. D. or other

Address: Reisterstown, Md. Date signed: 11-11-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-0)

CERTIFICATE OF DEATH

10756 37
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS/A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Cockeysville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs 7 Months
Hospital, institution, or street address where death occurred: Masonic Home, Cockeysville Md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County:
City or town: Catonsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 24 Wyncrest Ave (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Dr. Harry S. Arthur

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Ella Mable Moores Arthur
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 22, 1867

8. AGE: Years	Months	Days	If less than one day
78		17	hrs. min.

9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual occupation: Medical Doctor
11. Industry or business
FATHER 12. Name: John Arthur
FATHER 13. Birthplace: Pittsburgh Pa
MOTHER 14. Maiden name: Elizabeth Harmon
MOTHER 15. Birthplace: Baltimore Md
16. Informant: Laura M. Schroeder
Address: Masonic Home, Cockeysville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11 - 12 - 45 (month) (day) (year)
Cemetery or crematory: Druid Ridge Cemetery
Location: Edgemont, Baltimore Md
18. Funeral director: Geo. L. Boyer Jr.
Address: 1512 Hollins St.
19. Nov. 9 - 45 (Date rec'd by registrar) L. M. Schroeder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 8 19 45, at 11:00 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19 44, to Nov. 8 19 45
and that I last saw h... alive on Nov. 8 19 45

	DURATION
Immediate cause of death: Uremia	3 days
Due to: Chronic Interstitial Nephritis	2 yrs
Due to: Generalized Arterio sclerosis	5 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Wilbur F. Skillman M.D. M. D. or other
Address: 6 E. Biddle St Date signed: 11/8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164-2)

CERTIFICATE OF DEATH

10757 P

Reg. Dist. No. 37

1. PLACE OF DEATH:
County: Balto.
City or town: Broadway Rd. R.F.D. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 2 yrs.
Hospital, Institution, or street address where death occurred: Broadv Rd. R.F.D. Lutherville Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore, Md. (If outside city or town limits, write RURAL and give nearest town)
Street No.: 5018 E. Eager Street (If rural, give LOCATION)
2.(a) If veteran, name war: No.

3.(a) FULL NAME: William C. Bailey

3.(b) Social Security Number: 214-12-4092

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife: –
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 13, 1915

8. AGE: Years	Months	Days	If less than one day
30	3	19	hrs. min.

9. Birthplace: Floyd, S. C. (Town, county, and state)
10. Usual occupation: Salesman
11. Industry or business: Vendomat Co.
FATHER 12. Name: William Bailey
13. Birthplace: Unknown
MOTHER 14. Maiden name: Fannie Hatcher
15. Birthplace: –
16. Informant: Mr. Paul L. Bailey
Address: 5018 E. Eager St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/6/45 (month) (day) (year)
Cemetery or crematory: Meadowridge
Location: Howard Co., Md.
18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.
19. 11/5/45 (Date rec'd by registrar) A. W. Hedrick DM. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 1, 1945, at 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 2, 1945, to Nov 2, 1945, and that I last saw h[illegible] alive on [illegible], 19[illegible]

Immediate cause of death	DURATION
Bullet wound in Head.	Instant
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: 11-1-'45
Where did injury occur? Lutherville (City or town) Balto (County) Md. (State)
Injured at home, farm, industry, public place (where?): Brdwy. Rd.
Means of injury: 38 revolver Injured at work? No.

23. SIGNATURE: D. J. Eagles, M.D. M. D. or other
Address: Reisterstown, Md. Date signed: 11-2-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

10758

Reg. Dist. No. 37

1. PLACE OF DEATH:
County Baltimore
City or town Texas
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yr. 10 mo. 7 da.
Hospital, institution, or street address where death occurred:
Baltimore County Home
How long in hospital or institution? 2 yr. 10 mo. 7 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Robert Banks

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	

6.(b) Name of husband or wife Mrs Hattie Randel Banks
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 2 1888

8. AGE: Years	Months	Days	If less than one day
57	9	12	..... hrs. ..... min.

8. Birthplace Maryland. (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name Oliver Banks
13. Birthplace Maryland.

MOTHER
14. Maiden name Annie Harnell
15. Birthplace Maryland.

16. Informant Mrs Francis Grant.
Address 625 N. Caroline St Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 17, 1945 (month) (day) (year)
Cemetery or crematory St. Stephens Cem
Location Back River

18. Funeral director Mrs Robert A. Elliott & dept.
Address 1129 N. Caroline St.

19. Nov. 15 1945 (Date rec'd by registrar) Wm J. Schilcoat Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1945, at 11 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 8 1943, to Nov 14 1945
and that I last saw h. alive on 11/14 1945

Immediate cause of death	DURATION
Diabetes Mellitis (Coma)	3 yrs.
Due to	
Due to	
Other conditions Gangrene - ex treatus	

(Inelnde pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wilmer E. Ensor M.D. M. D. or other
Address Cockeysville Md Date signed 11/15/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (43a)

CERTIFICATE OF DEATH

10759

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years, 3 months, 30 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 2 years, 3 months, 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1935 W. Baltimore Street

(If rural, give LOCATION)

2.(a) If veteran, name war --

3.(a) FULL NAME ELLA GRACE BARLOW

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	single

6.(b) Name of husband or wife --

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 2, 1882

8. AGE:	Years	Months	Days	If less than one day
	62	11	19	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation bookkeaper; matron Retired

11. Industry or business Rosewood Training School

FATHER 12. Name Joseph M. Barlow

13. Birthplace Maryland (Howard Co., Md.)

MOTHER 14. Maiden name Katharine Martin

15. Birthplace Maryland (Balto.)

16. Informant Hospital records

Address Catonsville, Baltimore - 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/24/45 (month) (day) (year)

Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. 11/23 (Date rec'd by registrar) 1945 Harvey W. Miller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21, 1945, at 7:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 22, 1943, to Nov. 21, 1945 and that I last saw h... or ...alive on Nov. 21, 1945

	DURATION
Immediate cause of death: Pyelo-nephritis	Indef.
Due to: Carcinoma of uterine cervix	Indef.
Due to:	
Other conditions: Psychosis with carebral arteriosclerosis	Indef.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Robert E. Gardner M.D. Robert E. Gardner, M. D. M. D. or other

Address Baltimore - 28, Maryland Date signed 11/21/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

CERTIFICATE OF DEATH

10760 P

Reg. Diat. No. 41

1. PLACE OF DEATH:

County: Balto

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs

Hospital, institution, or street address where death occurred: 1821 Maxwell Ave

How long in hospital or institution? 6 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1821 Maxwell

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Ethel Barnes

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Alban C Barnes

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): May 1895

8. AGE: Years	Months	Days	If less than one day
50	5	13	...hrs. ...min.

9. Birthplace: Penna (Town, county and state)

10. Usual occupation: At home

11. Industry or business:

FATHER 12. Name: Ira M Blaney

FATHER 13. Birthplace: Pa

MOTHER 14. Maiden name: Elizabeth Green

MOTHER 15. Birthplace: Pa

16. Informant: Alban Barnes

Address: 1821 Maxwell Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 5/45 (month) (day) (year)

Cemetery or crematory: Oak Lawn Cemetery

Location: City

18. Funeral director: Collier Funeral Home

Address: 2008 Orleans St

19. 11-5-45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/2 19 45, at 1 50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 4/1 19 43 to 11/2 19 45

and that I last saw her alive on 11/2 19 45

Immediate cause of death	DURATION
Carcinoma of breast with metastasis	
Due to:	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: cancer of breast

Date of op. 10/30/44

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Ellis Greenberg M.D.

M. D. or other

Address: 4613 Eastern Ave Date signed 11/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

CERTIFICATE OF DEATH

10761

Reg. Dist. No. 43

1. PLACE OF DEATH:
County: Baltimore
City or town: Raspeburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
6330 Hamilton Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 6330 Hamilton Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: WILLIAM BARTENFELDER

3.(b) Social Security Number: 214-03-4680

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mary E. Bartenfelder
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 30th, 1884

8. AGE: Years	Months	Days	If less than one day
61	6	12	hrs. min.

9. Birthplace: Balto. Co., Md. (Town, county, and state)
10. Usual occupation: Electrical Engineer
11. Industry or business: S.S. 214-03-4680

FATHER
12. Name: August Bartenfelder
13. Birthplace: Unknown

MOTHER
14. Maiden name: Catherine Link
15. Birthplace: Unknown

16. Informant: Mrs. Wm. Bartenfelder
Address: 6330 Hamilton Ave.

17. burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 16, 1945 (month) (day) (year)
Cemetery or crematory: Zion Luthern Cemetery
Location: Stemmers Run, Md.

16. Funeral director: Lansdale Funeral Home
Address: 7401 Belair Road

19 Nov. 14 19 45 Mrs. G. L. Reifsnider
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 12th, 1945, at 5:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to 11/12 1945
and that I last saw him alive on 11/12 1945

Immediate cause of death: Coronary Embolism — DURATION: Instantaneous
Due to: Angina Pectoris
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Wright A. Seeder M. D. or other
Address: 5323 E. Balto St. Date signed: 11/13/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (W)

CERTIFICATE OF DEATH

10762

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore County
City or town: Stoneleigh
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1yr
Hospital, institution, or street address where death occurred: 646 Regester Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: BALTIMORE
City or town: BALTIMORE (STONELEIGH)
(If outside city or town limits, write RURAL and give nearest town)
Street No. 646 REGESTER AVE.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JOSEPH CAMERON BEARD

3.(b) Social Security Number: 579-22-5733

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of ~~husband~~ or wife: JESSIE ELIDA BEARD
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): AUGUST 27 1877

8. AGE: Years	Months	Days	If less than one day
68	2	4	..... hrs. ..... min.

9. Birthplace: PARKSBURG, CHESTER, PENNA.
(Town, county, and state)
10. Usual occupation: STEAM ENGINEER
11. Industry or business

FATHER
12. Name: JOSEPH CAMERON BEARD
13. Birthplace: NEAR ALTONA PENNA.

MOTHER
14. Maiden name: MARY BARBARA SEIBERT
15. Birthplace: WILLIAMSPORT PENNA.

16. Informant: J.G BEARD
Address: 211 HOMESTEAD AVE. HADDONFIELD NEW JERSEY

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: NOV 6 1945 (month) (day) (year)
Cemetery or crematory: CEMETERY (ROCK CREEK)
Location: WASHINGTON, D.C.

18. Funeral director: ~~SH[illegible]~~ A. Reiley Slade
Address: ~~WASH DC~~ 4907 York Road

19. 11/5 (Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 4 1945, at 3:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 15 19 45 to November 4 19 45
and that I last saw h[illegible] alive on November 3 19 45
Immediate cause of death: Respiratory Failure — DURATION: 8 hrs.

Due to: Cerebral Vascular Hemorrhage — 7 Days
Due to: Arteriosclerosis * Hypertension — 16 Yrs
Other conditions: Diabetes Mellitus — 18 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles F. O'Donnell, M. D. or other
Address: 230 York Rd Date signed: Nov 4, 1945

AFL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

10763

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Balto.
City or town: Middle River
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Middle River
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Paige Farm
(If rural, give LOCATION)
2.(a) If veteran, name war: World I

3.(a) FULL NAME (Ray Borton) Charles Beck.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	married

6.(b) Name of husband or wife: Rose Beck nee Kroll
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Feb 24 - 1890

8. AGE: Years	Months	Days	If less than one day
55	9	16	..... hrs. ..... min.

9. Birthplace: ~~Kentucky~~ Balto. Co., (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: Joseph S. Beck
FATHER 13. Birthplace: ? Balto. Co.
MOTHER 14. Maiden name: Fannie E. Engle
MOTHER 15. Birthplace: ? Balto. Md.
16. Informant: Rose Beck, Wife
Address: 1034 Harford Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof ~~Dec~~ 12-4-45 (month) (day) (year)
Cemetery or crematory: Balto. Natl.
Location: Frederick Road
18. Funeral director: John J. Connelly
Address: 418 Eastern Ave. Balto
19. 12/3 19 45 John J Connelly (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 28 19 45, at 9 45 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...
and that I last saw h... alive on ..... 19...

Immediate cause of death	DURATION
Coronary Occlusion	2 hours
Due to	Unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... injured at work?

23. SIGNATURE: W. McCammon M.D.
Deputy Medical Examiner
M. D. or other
Address: Baltimore, Md. Date signed: 12/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95(P)

CERTIFICATE OF DEATH

Reg. Diat. No. 10764

P

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 Days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland
How long in hospital or institution? 10 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of motber)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 46 E. Henrietta St.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-2 ✓

3.(a) FULL NAME: REUBEN M. BELL

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife: Single
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 22, 1900

8. AGE:	Years	Months	Days	If less than one day
	44	10	21	hrs. min.

9. Birthplace: Cambridge, Md.
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER
12. Name: Benjamin Bell
13. Birthplace: Maryland

MOTHER
14. Maiden name: Florence Vain
15. Birthplace: Maryland

16. Informant: Vets. Adm. Clinical Records
Address: Vets. Adm. Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 15, 1945 (month) (day) (year)
Cemetery or crematory: Cambridge
Location: Cambridge, Md.
18. Funeral director: John F. Denny, Inc.
Address: 715 Light St.
19. 11-13 45 (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 12, 1945, at 6:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 2, 1945 19 to November 12 1945 and that I last saw him alive on November 12, 1945

Immediate cause of death	DURATION
Embolism, Cerebral	11-9-45
Due to: Rheumatic Heart Disease	unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Lee Arm Balter
A. M. BALTER, LT. COL., M.C., D. CERT. DIR.
Address: Ft. Howard, Maryland Date signed: 11-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

Bc 10765 P

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4023 Lewiston Ave.,
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME

GEORGE BENNER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Widowed

6.(c) If alive, give age: yeers

7. Birth date of deceased (mo., day, yr.): 1-13-1890

8. AGE:	Yeers	Months	Days	If less than one dey
	55	9	25	....hrs. ....min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usuel occupation: Unemployed

11. Industry or business

FATHER 12. Name: George Benner

13. Birthplace: Maryland

MOTHER 14. Meiden name: Elizabath Roberts

15. Birthplace: Maryland

16. Informent: Clinical Records, Vets. Adm. Fac.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Dete thereof Nov 10 45 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland

18. Funeral director: A. Lee Oder
Address: 4644 York Road., Balto., Md.

19. 11/10 1945 A. W. Hedrick Registrar
(Date rec'd by registrar) D.M.

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 8, 1945, at 5:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 2, 1945 to November 8, 1945 and that I last saw h... im alive on November 8, 1945

Immediate cause of death	DURATION
Hemorrhage, Cerebral	5 Days
Due to: Hypertension, arterial	About March 1944
Due to:	
Other conditions: Broncho-pneumonia--terminal	

Heart disease-hypertension & coronary arteriosclerosis, and Hemiplegia, complete right.

Major findings of operations: Dete of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Dete of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A. M. Balter
A. M. BALTER, LT. COL., M.C. or C.E.N. DIR.

Address: Fort Howard, Maryland Date signed: 11-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10766

Reg. Diat. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson
(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 0 mos., 13 days

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 0 yrs., 0 mos., 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newboro infaots give resideoce of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or towo limits, write RURAL aod give oearest town)

Street No. 4215 Belmar Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Beatrice Bonomo

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Samuel J. Bonomo

6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): August 17, 1910

8. AGE: Years	Months	Days	If less than one day
35	2	25	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Arthur Redman
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Sadie Brown
15. Birthplace: New Jersey

16. Informant: Mrs. Beatrice Bonomo
Address: 4215 Belmar Ave., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 14, 1945 (month) (day) (year)

Cemetery or crematory: Lorraine Cemetery

Location: 5608 Dogwood Rd., Woodlawn, Md.

18. Funeral director: Frank V. Pipitone

Address: 2818 E. Baltimore St., Balto., Md.

19. Nov. 11, 1945 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 11, 1945, at 10:10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 29, 1945, to Novem. 11, 1945

and that I last saw h... er alive on November 11, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 Yr.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: Tuberculous Laryngitis	6 Mos.

(Include pregnaocy withio 3 months of deoth)

Major findings of operations: No operation

Date of op.:

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the followiog:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Meaos of injury: Injured at work?

23. SIGNATURE: Stewart S. Shaffer M.D. (M.D. or other)

Address: Mount Wilson, Md. Date signed: 11/11/45

Rec'd from Dr. E. E. Nichols 11-13-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

10767

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto.

City or town Essex

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

817 Silver Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Essex

(If outside city or town limits, write RURAL and give nearest town)

Street No. 817 Silver Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mabel Braughton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

6.(b) Name of husband or wife Willard F Braughton

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 31 - 1860

8. AGE: Years 85 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Kent Co., Md.

(Town, county, and state)

10. Usual occupation at Home

11. Industry or business —

FATHER 12. Name Edward Rollison

13. Birthplace Kent Co.

MOTHER 14. Maiden name Emily Simpson

15. Birthplace Md.

16. Informant Mrs Mabel Vogel (daughter)

Address 817 Silver Ave.

17. Burial Date thereof 11/17/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Carmel Cem.

Location O'Donnell St.

18. Funeral director John D Connelly.

Address 418 Eastern Ave. Essex 21

19. 11/15/45 John D Connelly.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14, 1945 at 5 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 1 1945, to Nov 14 1945

and that I last saw h.. alive on Nov 14 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Paul R. Estep M. D. or other

Address 2 Fenway S Balto 21 Date signed Nov. 14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

16768

Reg. Dist. No. 37

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Cockeysville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, institution, or street address where death occurred:

Masonic Home

How long in hospital or institution? 10 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore County

City or town: Towson Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 202 Baltimore Ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Miss Katharine Mary Brown

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, ~~married, widowed, or divorced~~
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 4, 1865

8. AGE: Years	Months	Days	If less than one day
80		21	hrs. min.

9. Birthplace: Baltimore County (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Carlton T. Brown

FATHER — 13. Birthplace: Baltimore County

MOTHER — 14. Maiden name: Elizabeth Ann Rebeau

MOTHER — 15. Birthplace: Baltimore County

18. Informant: Laura M. Schroeder

Address: Masonic Home, Cockeysville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 28 - 45 (month) (day) (year)

Cemetery or crematory: Prospect Hill

Location: Towson Md.

18. Funeral director: Geo. L. Beyer Jr.

Address: 1512 Hollins St

19. 11-26 19 45 L M Schroeder (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 25 19 45, at 3 45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 38 to Nov. 25 19 45 and that I last saw h-r alive on Nov. 25 19 45

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to: Arterio sclerosis	5 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wilbur F. Shellman M.D. M. D. or other

Address: 6 E. Biddle St Date signed: 11/25/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

10769 P

Reg. Dist. No. 40

1. PLACE OF DEATH:
County: Baltimore
City or town: Upper Falls
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto.
City or town: Upper Falls
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Elliott Brown

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

8.(b) Name of husband or wife: Jas. Carrington Brown
6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.): July 4 1873

8. AGE: Years 72 | Months 4 | Days 9 | If less than one day ... hrs. ... min.

9. Birthplace: Flushing Long Island
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Henry Bowman
13. Birthplace: N.Y.

MOTHER 14. Maiden name: Mary Liddy ?
15. Birthplace

16. Informant: Mr Jas. Carrington Brown
Address: Upper Falls Balto Co Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 15 1945 (month) (day) (year)
Cemetery or crematory: Green Mount
Location: Balto Md

18. Funeral director: Henry M. Jenkins & Son
Address: McCulloh & Orchard Sts

19. 11/14 1945 (Date rec'd by registrar) A. W. Hedrick (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 13 1945 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 11 1945 to Nov. 13 1945
and that I last saw h[illegible] alive on November 12 1945

	DURATION
Immediate cause of death: a. Broncho pneumonia	24 hrs
Due to: Cerebral Hemorrhage (Multiple)	6 Mos.
Due to: Essential Hypertension	15 yrs (?)
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Lloyd F. Hudson, M.D.
M. D. or other
Address: York Rd Date signed 11/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Recd
11/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

10770

CERTIFICATE OF DEATH

★ Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 months
Hospital, institution, or street address where death occurred: Hoods Convalescent Home
How long in hospital or institution? 9 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Towsontown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2900 Pennsylvania Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Alvina V. Burns

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Basil P. Burns
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 29, 1858

8. AGE: Years	Months	Days	If less than one day
87	4	12	..... hrs. ..... min.

9. Birthplace: Montgomery County, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: William J. Brandenburg
13. Birthplace: Maryland
MOTHER 14. Maiden name: Unknown
15. Birthplace: Maryland
16. Informant: Mrs. Jessie Dietrich
Address: 2900 Pennsylvania Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-13-45 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore Maryland
18. Funeral director: George L. Schwab
Address: 2101 Frederick Ave Balto, Md.
19. 11/12 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 10, 19 45, at 4:00 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 19 45 to Nov 10 19 45
and that I last saw h..... alive on Nov 10 19 45

Immediate cause of death	DURATION
(a) Endocarditis with Gangrene of Foot	2 wks
Due to: (b) Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: /
Date of op. .....
Autopsy results: /
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: / Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: [illegible] Date signed 11/13

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Chilcote Texas Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (169)

CERTIFICATE OF DEATH

10771

★ Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Texas
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred:
Texas-Lane and Penna. R.R.Track
How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Texas
(If outside city or town limits, write RURAL and give nearest town)
Street No. ----
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME Charles Arthur Bush

3.(b) Social Security Number 225-30-2553

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ----
6.(c) If alive, give age: --

7. Birth date of deceased (mo., day, yr.): February 28, 1928

8. AGE: Years	Months	Days	If less than one day
17	8	7	....hrs. ....min.

9. Birthplace: McGaheysville, Virginia (Town, county, and state)
10. Usual occupation: Laborer (General)
11. Industry or business: Harry T. Campbell Co.

FATHER
12. Name: Charles S. Bush
13. Birthplace: Virginia

MOTHER
14. Maiden name: Viola Fold
15. Birthplace: Virginia

16. Informant: Charles S. Bush
Address: McGaheysville, Virginia

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Nov. 6 1945 (month) (day) (year)
Cemetery or crematory: W.O.Brill, Funeral Home
Location: Elkton, Virginia
18. Funeral director: John Burns Sons
Address: Towson, Maryland
19. Nov 6 19 45 (Date rec'd by registrar) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 4, 1945 at 7.35 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....
and that I last saw h... alive on ....19....

	DURATION
Immediate cause of death: Crushed shoulder - Struck by train - Accident	11/4/45
Due to: Multiple fractures, left shoulder, arm, right shoulder	11/4/45
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:
Accident, suicide, or homicide: Accident Date of: Nov 4, 1945.
Where did injury occur? Texas (City or town) Baltimore (County) Md. (State)
Injured at home, farm, industry, public place (where?): Public RR crossing.
Means of injury: Struck by RR. train Injured at work? No

23. SIGNATURE: Rollin C. Hudson M.D. D.M.E. M. D. or other
Address: Towson 4, Md. Date signed: 11/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (7-52)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 10772 37

1. PLACE OF DEATH:
County: Baltimore
City or town: Cockeysville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? ~~55~~ 54 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Cockeysville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Florence Addie Lee Butler

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Nicholas Woodward Butler
6.(c) If alive, give age: 82 years

7. Birth date of deceased (mo., day, yr.): Jan 11, 1869

8. AGE: Years	Months	Days	If less than one day
76	9	25	..... hrs. ..... min.

9. Birthplace: Frederick Co. Md.
(Town, county, and state)
10. Usual occupation: Homemaker
11. Industry or business:
FATHER 12. Name: Jerome Anderson
13. Birthplace: Unknown
MOTHER 14. Maiden name: Frances Bafset
15. Birthplace: Unknown
16. Informant: N. W. Butler
Address: Balto. Co. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 9 1945 (month) (day) (year)
Cemetery or crematory: Parkwood Cem.
Location: Baltimore, Md.
16. Funeral director: Sandon & Bowles
Address: Sparks, Md.
19. 11-7-45 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 6 1945 at 11:30 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1945 to Nov 6 1945
and that I last saw her alive on Nov 6 1945

Immediate cause of death	DURATION
Coronary Thrombosis	5 days
Due to: Myocarditis	2 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wilmer C. Ensor M.D. (M. D. or other)
Address: Cockeysville Md. Date signed: 11/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

10773

CERTIFICATE OF DEATH

Reg. Dist. No. 4-2

1. PLACE OF DEATH:
County: Baltimore
City or town: Halethorpe
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 yrs
Hospital, institution, or street address where death occurred:
5-553 Linda
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Halethorpe
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5-553 Linda ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Bertha Pauline Carback

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William Arthur Carback
6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): Oct 15 - 1909

8. AGE: Years	Months	Days	If less than one day
36	0	21	...hrs. ...min.

9. Birthplace: Baltimore City Md (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: Home work
FATHER 12. Name: John Sheaffer
13. Birthplace: North Carolina
MOTHER 14. Maiden name: Pauline Miller
15. Birthplace: Baltimore, Md
16. Informant: Mrs. Wm. A. Carback
Address: 5-553 Linda ave, Halethorpe Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 8/45 (month) (day) (year)
Cemetery or ~~crematory~~: Loudon Park.
Location: Frederick Road.
18. Funeral director: Ehrenwerth & Donovan
Address: 3615-17 Chestnut Ave.
19. Nov 6 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 5 19 45, at 12 02 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 19 39, to Nov 5 19 45 and that I last saw h er alive on Nov 4 19 45

Immediate cause of death	DURATION
Bronchopneumonia	3 da
Due to: Bronchiectasis	10 Yrs
Due to: Chr. myocarditis	5 Yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ...Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: B B Brumbaugh M.D.
5609 Wash st Elk Md M. D. or other
Address: ...Date signed: 11-6-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

10774 P

Reg. Dist. No. 38

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Baltimore
City or town: Mt Washington, Baltimore 10
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Mt Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6015 Altamont Place
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Richard Randolph Mason Connolly

3.(b) Social Security Number: 218-07-9275

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lela M. Connolly
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 12 1874

8. AGE: Years: 71 | Months: 4 | Days: 16 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore Co. Maryland
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business:

FATHER
12. Name: William Connolly
13. Birthplace: Harford Co. Maryland

MOTHER
14. Maiden name: Sarah Merryman
15. Birthplace: Baltimore Co. Maryland

16. Informant: Mrs. Lela M. Connolly
Address: 6015 Altamont Place

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 1 1945 (month) (day) (year)
Cemetery or crematory: Hereford Baptist
Location: Baltimore Co. Maryland

18. Funeral director: Burgee Funeral Home
Address: 3631 Falls Road

19. 11/30 1945 (Date rec'd by registrar) R W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 28 1945 at 10 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from None 19..... to ..... 19.....
and that I last saw h..... alive on None 19.....

	DURATION
Immediate cause of death: Coronary thrombosis	11/28/45
Due to: Catarrhal fever	1 weeks
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Rollin C. Hudson MD. D.M.E.
M. D. or other
Address: Towson 4 Md Date signed 11/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

10775

CERTIFICATE OF DEATH

★ Reg. Dist. No. 37

1. PLACE OF DEATH

County: Baltimore

City or town: Phoenix P.O. Mayor Rd, Sweet Air

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Phoenix

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Mayor Rd.

(If rural give LOCATION)

2.(a) If veteran, name war: None known

3.(a) FULL NAME George Thomas Conway

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 19, 1866

8. AGE: Years	Months	Days	If less than one day
78	11 +		..... hrs. ..... min.

9. Birthplace: Baltimore City Md.
(Town, county, and state)

10. Usual occupation: Retired (Formerly United R.R.

11. Industry or business: None position unknown.

FATHER 12. Name: George Thomas Conway (Sr.?)

FATHER 13. Birthplace: Baltimore, Md.

MOTHER 14. Maiden name: Anne (Unknown)

MOTHER 15. Birthplace: Baltimore Md.

16. Informant: Mrs. Mary Moore (Neice)

Address: Phoenix, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 4, 1945 (month) (day) (year)

Cemetery or crematory: St. John's Lutheran Cem.

Location: Sweet Air, Balto. Co., Md.

18. Funeral director: John Burns' Sons

Address: Towson, Md.

19. Nov 4 1945 (Date rec'd by registrar) Wilmer C. Ensor Registrar

Received Nov. 20th-45

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 2 1945 at 11-A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive on ..... 19.....

Immediate cause of death	DURATION
(a) Coronary heart disease	
chronic myocarditis	5 yrs +
Due to: (b) Arteriosclerosis	unk
Senile changes	unk
Due to: (c)	
Other conditions: Left inguinal hernia	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Rollin C. Hudson MD, D.M.E.
M. D. or other

Address: Towson 4, Md. Date signed 11/2/45.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83

10776 P

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Balto Co.

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mo

Hospital, institution, or street address where death occurred:

City Home

How long in hospital or institution? 2 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 48 Ridge Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Maryland Cook

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

6.(b) Name of husband or wife: Lambert T. Cook

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 24 1860

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
85	6	1		

9. Birthplace: Va.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER — 12. Name: Edward [illegible]

13. Birthplace: Va.

MOTHER — 14. Maiden name: Patrick A Christian

15. Birthplace: Va

16. Informant: Mary J Pickett

Address: 48 Ridge Road

17. (Burial, cremation, or removal. Which?) Burial — Date thereof: 11/21/45 (month) (day) (year)

Cemetery or crematory: Hillside

Location: Mansfield N.J.

18. Funeral director: Edw. S. Mar[illegible]

Address: Catonsville Md.

19. 11-20 1945 — [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 18 1945, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1945 to Nov 18 1945 and that I last saw her alive on Nov 18 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 days
Due to: Cerebral Arterio Sclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of: ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ____

Means of injury: ____ Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Catonsville Date signed: 11-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

10777

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Ship yard on R.R.
How long in hospital or institution? 10 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Co City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 514 N. Lowdon Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph Creaghan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Steela Agnes Mc Grant
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Dec 2nd 1892

8. AGE: Years: 53 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Engineer, Rail Road

11. Industry or business: Bethlehem Steel Co.

FATHER
12. Name: Patrick Creaghan
13. Birthplace: Ireland

MOTHER
14. Maiden name: Margaret O'Brian
15. Birthplace: Md.

16. Informant: Mrs. Joseph F. Creaghan
Address: 514 Lowdon Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/6/45 (month) (day) (year)
Cemetery or crematory: Carbedine
Location: bet Frederick Rd.

18. Funeral director: J. J. Foley & Sons
Address: 1318 Light St.

19. 11/5 1945 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 2 1945, at 9:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Coronary occlusion — DURATION: 2 hrs.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. McCarmine M.D.
M.D. or other
Address: Dundalk Md Date signed: 11/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10779

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Baltimore

City or town: Gray Manor (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: .....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Dundalk - 22 - md (If outside city or town limits, write RURAL and give nearest town)

Street No.: 207 Ashwood Rd. (If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME: Helen N. Cutlup

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Bailey L. Cutlup

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 1, 1922

8. AGE: Years	Months	Days	If less than one day
23	5		..... hrs. ..... min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: at home

11. Industry or business .....

FATHER — 12. Name: John Hoffman

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Nettie Muehlburger

MOTHER — 15. Birthplace: Germany

16. Informant: Bailey L. Cutlup

Address: 207 Ashwood Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/4/45 (month) (day) (year)

Cemetery or crematory: Mt. Carmel

Location: O'Donnell St.

18. Funeral director: Clarence F. Hoffmann

Address: 1639 N. Broadway

19. 12/3 1945 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 30 - 1945 - at 7 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 23 - 1945 to November 30 - 1945 and that I last saw her alive on November 29 - 1945

Immediate cause of death	DURATION
Pulmonary Embolism	Sudden
Due to: Occlusion of Iliac Vessels	one week
Due to:	
Other conditions: Six months pregnant	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. .....

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Dawson L. Harber M. D. or other

Address: Sparrows Point - 19 - Md. Date signed 11/30/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10778 P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 153 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Fort Howard, Maryland
How long in hospital or institution? 153 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 502 Carrollton Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: JESSE DAYS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Mrs. Ocie Days
6.(c) If alive, give age: 45 years
7. Birth date of deceased (mo., day, yr.): 11-22-94

8. AGE: Years	Months	Days	If less than one day
51			hrs. min.

9. Birthplace: Gainesville, Florida (Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business

FATHER
12. Name: Joseph Days
13. Birthplace: Carolina

MOTHER
14. Maiden name: Lizzie Brown
15. Birthplace: Carolina

16. Informant: Clinical Records, Vets. Adm.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 27, 1945 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland

18. Funeral director: Charles R. Law
Address: 802 Madison Ave., Balto., Md.

19. 11/24/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 22, 1945, 5:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 22, 1945, to November 22, 1945 and that I last saw him alive on November 22, 1945

Immediate cause of death	DURATION
Cerebral thrombosis with right hemiplegia	11/20/45
Due to:	
Due to:	
Other conditions: Disease of the heart-- Hypertension & Coronary Arteriosclerosis, Myocardial insufficiency (Include pregnancy within 3 months of death)	5Mos plus

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. M. BALTER, LT. COL., M. C. CLIN. DIR.
Address: Fort Howard, Md. Date signed: 11-23-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

10780

★ Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6yr 6mo 17da
Hospital, Institution, or street address where death occurred:
Rosewood St. Training School
How long in hospital or institution? 6yr 6mo 17da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rosewood State Training School
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Rosalie DePasquale

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: -----
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): 7/14/32

8. AGE: Years	Months	Days	If less than one day
13	3	30	....hrs. ....min.

9. Birthplace: Baltimore, Baltimore, Md. (Town, county, and state)
10. Usual occupation: Inmate
11. Industry or business: ---

FATHER
12. Name: Michael Angelo DePasquale
13. Birthplace: Maryland

MOTHER
14. Maiden name: Carrie Parks
15. Birthplace: Maryland

16. Informant: Institutional records
Address: Rosewood St. Trng. School

17. (Burial, cremation, or removal. Which?) Burial
Date thereof: NOV 14-45 (month) (day) (year)
Cemetery or crematory: Moreland park memorial
Location: Taylor ave. Balto. Md

18. Funeral director: Frank H. Mauer & Co.
Address: Pikesville, Maryland

19. 11-14-1945 (Date rec'd by registrar) E. E. Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 13 19 45, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27 19 39, to Nov. 13 19 45
and that I last saw her alive on November 12 19 45

Immediate cause of death	DURATION
Broncho-pneumonia	5 da
Due to: Bronchitis	2 da
Due to:	
Other conditions: Grand mal epilepsy (since 1933?) Hemiplegia	6½yr + since birth

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Rachel H. M. Clinton M.D.
M. D. or other
Address: Owings Mills, Md. Date signed: 11/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-B)

10781

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Balto.

City or town Fullerton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred: Joppa Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Balto.

City or town Fullerton (If outside city or town limits, write RURAL and give nearest town)

Street No. Joppa Rd (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Frieda B. Dietz

3. (b) Social Security Number —

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife —

6.(c) If alive, give age .... years

7. Birth date of deceased (mo., day, yr.) 2/6/25

8. AGE: Years 20 Months 9 Days 9 If less than one day ....hrs. ....min.

9. Birthplace Balto. Co. Md (Town, county, and state)

10. Usual occupation at home

11. Industry or business

FATHER 12. Name Christian P. Dietz

13. Birthplace Balto. Co. Md.

MOTHER 14. Maiden name Johanna K. Hanf

15. Birthplace Balto. Co. Md.

16. Informant Mrs W. Fischer

Address Fullerton P.O. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11 18 45 (month) (day) (year)

Cemetery or crematory St. Michaels Luth.

Location Balto. Co. Md

18. Funeral director Lassahn Funeral Home

Address 7401 Belair Rd.

19 11-16-45 (Date rec'd by registrar) W. O. Kommuth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15th 1945, at 11[20] A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 12 1945, to Nov. 15 1945

and that I last saw her alive on Nov. 10, 1945

Cause	Duration
Immediate cause of death: Congestive Heart Failure	5 days
Due to: Rheumatic Carditis with Mitral Insufficiency and Mitral Stenosis.	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clifford T. Hudson, M.D. M.D. or other

Address W. Fork, Md. Date signed 11/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

10782

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Months, 8 Days

Hospital, institution, or street address where death occurred:
Nellie Hood Nursing Home

How long in hospital or institution? 2 Months, 8 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Kenwood & Cliftwood Aves. Raspeburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Kenwood & Cliftwood Aves. Raspeburg
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Catherine B. Donat

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Winfield S. Donat

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 5 th. 1881

8. AGE: Years	Months	Days	If less than one day
64	8	23	..... hrs. ..... min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: At Home

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. H. Clifton McCormick

Address: 5201 Kenwood Ave. Balto. 6 Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 30th. 1945 (month) (day) (year)

Cemetery or crematory: Parkwood

Location: Baltimore, Maryland

18. Funeral director: Lassahn Funeral Home

Address: 7401 Belair Road

19. ..... 19..... (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH: November 28th. 1945 at 5.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1945 to Nov 28 1945 and that I last saw h... alive on Nov 28 1945

Immediate cause of death	DURATION
Carcinoma of Stomach	8 mon
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Ca of Stomach

Date of op. 1945

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: ..... M. D. or other

Address: Baltimore Md. Date signed 11/28

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10783 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore County
City or town: Parkville, Edgewood Rd - Zone 14
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? About 4 mos.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: B
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1617 Clarkson St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Mary Dooley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William E. Dooley
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 8, 1872

8. AGE: Years	Months	Days	If less than one day
73		1	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: At Home
11. Industry or business

FATHER
12. Name: William Keller
13. Birthplace: Germany

MOTHER
14. Maiden name: Christina Bach
15. Birthplace: Germany

16. Informant: William Keller (Brother)
Address: Edgewood Rd. Parkville, Balto. Co., Zone 14 Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 13, 1945 (month) (day) (year)
Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Md.

18. Funeral director: A. R. Coward Evans
Address: 1400 S. Charles St. Balto. 30, Md.

19 Nov. 12 19 45 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 9, 1945 at 2:00 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 1945, to Nov. 9 1945
and that I last saw h alive on November 8th (Nov. 7th) 1945

Immediate cause of death: Carcinoma Esophagus — DURATION: 6 Mo.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C. W. Peake M. D. or other
Address: 4208 Harford Rd. Date signed: 11-10-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10784

Reg. Diat. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 5 mos., 22 days

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 0 yrs., 5 mos., 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 42 E. Washington Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mr. Owen Dorer

3.(b) Social Security Number: 214-14-6753

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Isabelle Dorer

6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): June 9, 1916

8. AGE: Years	Months	Days	If less than one day
29	5	2	...hrs. ...min.

9. Birthplace: Hagerstown, Maryland
(Town, county, and state)

10. Usual occupation: Inspector (Aircraft Co.)

11. Industry or business

FATHER 12. Name: Ralph Dorer

FATHER 13. Birthplace: Hagerstown, Maryland

MOTHER 14. Maiden name: Lowella M. Routzhan

MOTHER 15. Birthplace: Quincy, Pennsylvania

16. Informant: Owen Dorer

Address: 42 E. Washington St., Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 14, 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: Fred W. Kraus

Address: 139 N. Potomac St., Hagerstown, Md.

19. Nov. 11, 1945 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 11, 1945, at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20, 1945, to Nov. 11, 1945 and that I last saw him alive on November 11, 1945

Immediate cause of death	DURATION
Diabetes Mellitus	6 Yrs.
Due to:	
Due to:	
Other conditions: Pulmonary Tuberculosis	9 Mos.

(Include pregnancy within 3 months of death)

Major findings of operations: No operation Date of op.:

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Stewart S. Shaffer M.D.
M. D. or other

Address: Mount Wilson, Md. Date signed: 11/11/45

Rec'd by Dr. E E Nichols - 11-13-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

10785

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville 28
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs. 1 mo. 4 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 2 yrs. 1 mo. 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore ~~City~~ Co.
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6813 Belair Road
(If rural, give LOCATION)
2.(a) If veteran, name war: Unknown

3.(a) FULL NAME: Stephen Earnest

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 4, 1870

8. AGE: Years	Months	Days	If less than one day
75	8	20	....hrs. ....min.

9. Birthplace: New York Place Unknown
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Catonsville 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 6, 1945 (month) (day) (year)
Cemetery or crematory: Spring Grove State Hospital
Location: Catonsville 28, Maryland

18. Funeral director: Spring Grove State Hospital
Address: Catonsville 28, Maryland

19. 11-28 1945 (Date rec'd by registrar) Harry A. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 24, 1945, at 12:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 20 1943 to Nov. 24 1945 and that I last saw him alive on Nov. 23 1945

Immediate cause of death	DURATION
Hypostatic Pneumonia Both lower lobes	2 days
Due to: Arteriosclerotic Gangrene left foot	3 wks.
Other conditions: Senile Psychosis	Indefinite

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.
Autopsy results: As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Jordan Funk, M.D. (M. D. or other)
Address: Spring Grove State Hosp. Date signed: 11-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

10786

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Balto.

City or town: Relay
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
1531 Rolling Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: -- Balto.

City or town: Relay
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1531 Rolling Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: SARAH F. EMERSON

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: John R. Emerson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 21, 1855

8. AGE: Years	Months	Days	If less than one day
90	5	29	..... hrs. ..... min.

9. Birthplace: Limerick, Maine
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: William Stimson
13. Birthplace: Maine

MOTHER
14. Maiden name: Mary Lord
15. Birthplace: Maine

16. Informant: Mrs. Eva E. Kilbourn
Address: 1531 Rolling Rd. 27

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 11/22/45 (month) (day) (year)
Cemetery or crematory: Cedar Grove Cem.
Location: Dorchester, Mass.

18. Funeral director: WILLIAM J. TICKNER & SONS
Address: Balto., Md.

19. 11/21 (Date rec'd by registrar) 19 45 Harry W. Miller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 20 1945, at 8 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 15 to Nov 20 1945
and that I last saw h.. alive on Nov 20 1945

	DURATION
Immediate cause of death: Cerebral accident	30 min.
Due to: Arterio Sclerosis -	4 years
Due to: ✓	
Other conditions: ✓	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ✓ Date of: ✓
Where did injury occur? ✓ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ✓ Injured at work?

23. SIGNATURE: Frederic V. Bentley M. D. or other
Address: Medical Arts Bldg. Balto. Date signed: 11-21-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-3)

CERTIFICATE OF DEATH

10787

Reg. Diat. No. 40

1. PLACE OF DEATH:

County: Baltimore

City or town: Hotel Cliff near Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Hotel Cliff near Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Sister Mary Ernesta

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 11 - 1874

8. AGE: Years	Months	Days	If less than one day
71		6	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Teacher

11. Industry or business

FATHER

12. Name: Ernest

13. Birthplace: Germany

MOTHER

14. Maiden name: Anna Helfenstein

15. Birthplace: Germany

16. Informant: Sr. Mary Clara

Address: Infirmarian

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 19/45 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: Glen Ellen

18. Funeral director: Geo. M. Frick & Son

Address: 811 N. Wolfe St.

19. 11/18/45 - [signature] Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 17 19 45, at 9.00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 12 19 45, to Nov. 17 19 45

and that I last saw h.. alive on Nov. 14 19 45

	DURATION
Immediate cause of death: Carcinomatosis Gastric	1 yr.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Date signed

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

10788

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Talbot
City or town Royal Oak
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Isabel Fegley

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife Richard S. Fegley
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years	Months	Days	If less than one day
82			..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual occupation at home
11. Industry or business
FATHER 12. Name Wm J Robinson
13. Birthplace Md
MOTHER 14. Maiden name Unknown
15. Birthplace "
16. Informant Adaline Christfield
Address 117 Buckwood ave Catonsville
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-28-45 (month) (day) (year)
Cemetery or crematory St Johns
Location Elkwood City Md.
18. Funeral director J.C. Register undertaker
Address Elkwood City Md
19. 11-27 1945 (Date rec'd by registrar) Harry D. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 Th 1945 at ..... M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 17 1945 to Nov 25 1945
and that I last saw her alive on Nov 23 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 hrs
Due to Auricular Fibrillation	1 mo ?
Due to Vascular Renal Disease	2 mo ?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Geo W Elliott M. D. or other
Address 803 3rd Ave Date signed Nov 26, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10789

Reg. Dist. No. 38

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
254 E. Susquehanna Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylvania County: ~~Baltimore~~ Montgomery
City or town: ~~Baltimore~~ Fort Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Summit Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Howard Franklin Flack

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Lillian Broom Flack
6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.): August 22, 1868

8. AGE: Years	Months	Days	If less than one day
77	2	28	— hrs. — min.

9. Birthplace: Doylestown, Penna.
(Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: Retired
FATHER 12. Name: John Flack
13. Birthplace: Penna.
MOTHER 14. Maiden name: Eliza Bailey
15. Birthplace: Penna.
16. Informant: Mrs. Doris Brown
Address: 254 E. Susquehanna Ave, Towson, Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof Nov. 21, 1945 (month) (day) (year)
Cemetery or crematory: W.C. Narcoe, Funeral Home
Location: Wycombe, Bucks Co., Penna.
18. Funeral director: John Burns Sons
Address: Towson, Md.
19. Nov 21 1945 (Date rec'd by registrar) A.W. Hedgecock per Walk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 20, 1945, at 5 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 1945, to Nov 18 1945
and that I last saw him alive on Nov 18, 1945

Immediate cause of death	DURATION
Carcinoma - (Sigmoid)	3 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operation: Carcinoma of Sigmoid
Date of op.: Aug 8, 45
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Towson-4-Md. Date signed 11/20/45

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (64)

Registered No. 10790

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Ridge
(b) Street address 332 ~~Ridge~~ Avenue
(c) Hospital or institution: Towson, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 332 ~~Ridge~~ Avenue
(Ridge is location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country —

3 (a) FULL NAME Donald Gillett Foreman, Jr.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Baby

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1945

8. AGE: Years	Months	Days	If less than one day
—	2	17	— hr. — min.

9. Birthplace Cumberland, Md. (Town, county, and state)
10. Usual Occupation Babe
11. Industry or business "

FATHER
12. Name Donald G. Foreman
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Eve May Cheadster
15. Birthplace Cumberland, Md.

16 (a) Informant Mrs. Donald G. Foreman
(b) Address 332 Ridge Ave., Towson, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 26, 1945 (month) (day) (year)
(c) Cemetery or crematory Moreland Park Cemetery
Location Parkville, Balto. Co., Md.

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Md.

19 (a) 11/26/45 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24, 1945, at 11 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pertussis
Status Thymico-lymphaticus.
Due to Enlargement of thymus. cw.s.r.
Other Conditions —
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Nov. 25 1945

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10791

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

★ Reg. Diat. No. 44

1. PLACE OF DEATH:
County Balto.
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No. 123 Eastern Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Mamie Frett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Lee J. Frett
6.(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Feb 13th 1889

8. AGE: Years	Months	Days	If less than one day
56			hrs. min.

9. Birthplace Md
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name John Wolfarman
13. Birthplace Md
MOTHER 14. Maiden name Catherine Huber
15. Birthplace Md
16. Informant Mr. Lee J. Frett
Address 123 Eastern Ave
17. Burial Date thereof Nov 23rd 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Oak Lawn
Location Eastern Ave Road
18. Funeral director Leo G. Crook
Address 1701-03 N Patterson Park Ave
19. Nov. 20 1945 John D. Donnelly Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18th 1945 at 1.10 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1945 to Nov 18 1945
and that I last saw h alive on Nov 18 1945

Immediate cause of death	DURATION
Acute Coronary occlusion	18 days
Due to	
Due to	
Other conditions Chronic Gall Bladder	?

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Edward M. Hummel M. D., or other
Address Essex Md Date signed 11/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

10792 P

Reg. Dist. No.

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: N. Paradise Ave mr Ted an
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town Catonsville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. N. Paradise Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: JOSEPH FULLER

3. (b) Social Security Number: 219-05-8322

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Henrietta Fuller
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1892

8. AGE:

Years	Months	Days	If less than one day
53	3	25	hrs. min.

9. Birthplace Catonsville, Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Allen Fuller
13. Birthplace Md.

MOTHER
14. Maiden name Eliza Gray
15. Birthplace Md.

16. Informant Mrs. Henrietta Fuller
Address N. Paradise Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-20-45 (month) (day) (year)
Cemetery or crematory Western Star Cem.
Location Catonsville, Md.

18. Funeral director Mrs. Frances A. Hemsley
Address 578 W. Biddle St.

19. 11-19 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

7-3 P

20. DATE OF DEATH November 16, 1945, at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h alive on ____ 19__.

Immediate cause of death	DURATION
Coronary occlusion	
Due to	
Due to Cardiac Vascular disease	
Other conditions sudden death	
Major findings: Enquiry	
Of operations	
Of autopsy	

(Include pregnancy within 3 months of death)

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Geo. M. Kieffer Deputized Examiner Balto
M. D. or other
Address 1010 Leeds Ave Date signed 11-16-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10793 P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 days

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 244 South Eden Street (If rural, give LOCATION)

2.(a) If veteran, name war: --

3.(a) FULL NAME Mary E. Gast

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	divorced

6.(b) Name of husband or wife: John Gast

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 10, 1890

8. AGE: Years	Months	Days	If less than one day
55	--	9	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: own home

FATHER — 12. Name: George Lohman

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Melvina Yingling

MOTHER — 15. Birthplace: Maryland

16. Informant: Hospital records

Address: Catonsville, Baltimore - 28, Md.

17. Burial (Burial, ~~cremation~~, or removal. Which?) Date thereof 11/24/45 (month) (day) (year)

Cemetery or ~~crematory~~: Mt. Carmel

Location: Balto. Md.

18. Funeral director: William Cook Inc.

Address: 1217 St. Paul St

19. 11/24 1945 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 19, 1945 at 8:03 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 24, 1945 to Nov. 19, 1945 and that I last saw her alive on Nov. 19, 1945

	DURATION
Immediate cause of death: Pulmonary edema	2 days
Due to: Myocardial degeneration	Indef.
Due to:	
Other conditions: Chronic alcoholism with deterioration	Indef.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.

Robert E. Gardner, M. D. M. D. or other

Address: Baltimore - 28, Md. Date signed: 11/20/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10794

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Maryland

How long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1827 Ramsey Street
(If rural, give LOCATION)

2.(a) If veteran, name war: SAW

3.(a) FULL NAME: JOHN K. GEARHART

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Ella M. Gearhart

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): 9-20-77

8. AGE:	Years	Months	Days	If less than one day
	68	2	2	...hrs. ...min.

9. Birthplace: Poplar Springs, Md.
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER
12. Name: Miles Gearhart
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Elizabeth Albert
15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 26/1945 (month) (day) (year)

Cemetery or crematory: U. S. National

Location: Baltimore

18. Funeral director: Robt C. & B. Wm. Walters

Address: 121 S. Stricker St

19. 11-24 (Date rec'd by registrar) 19 45 A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 22, 1945 at 10:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 16, 1945 to November 22, 1945 and that I last saw h. i.m. alive on November 22, 1945

Immediate cause of death	DURATION
PNEUMONIA LOBULAR	3 Days
Due to:	
Due to:	
Other conditions: Arthritis spine (Marie Strumpells type)	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work? NM

23. SIGNATURE: A. M. Balter

A.M. BALTER, LT. COL., M.C.M. CLIN. DIR.

Address: Fort Howard, Maryland Date signed: 11-23-45

VS A15 9.45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

10795

Reg. Diat. No. 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Raspeburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?: life

Hospital, institution, or street address where death occurred:

1028 Chesaco Ave.

How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Raspeburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1028 Chesaco Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: LOTTIE E. GEBHARDT

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: George J. Gebhardt

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 25, 1895

8. AGE:

Years	Months	Days	If less than one day
50	1	29	hrs. min.

9. Birthplace: Balto. Co., Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Andrew Eckstein

13. Birthplace: Balto., Md.

MOTHER

14. Maiden name: Margaret Frank

15. Birthplace: Balto. Co., Md.

16. Informant: Mr. George J. Gebhardt

Address: 1028 Chesaco Ave., Raspeburg, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 28th, 1945 (month) (day) (year)

Cemetery or crematory: Oak Lawn

Location: Balto., Md.

18. Funeral director: Lansdale Funeral Home

Address: 7401 Belair Road

19. Nov. 26 1945 (Date rec'd by registrar) John D. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 24th, 1945 at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1st 1945 to Nov 23rd 1945 and that I last saw h[illegible] alive on Nov 23 1945

Immediate cause of death	DURATION
Cardiac Failure	
Due to: Carcinoma of left Breast	
Due to: Metastasis in left Lung and Bones	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of left Breast Date of op. 1944

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. J. Sankin M. D. or other

Address: 100 N. Milton Av Date signed: 11/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Diat. No. 44

10796

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2325 Lafayette Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war Spanish American War

3.(a) FULL NAME EDWARD A. GEHRMANN

3.(b) Social Security Number [illegible]

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

8.(b) Name of husband or wife Madeleine Gehrmann

8.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) April 9, 1861

8. AGE: Years	Months	Days	If less than one day
84	7	1	...hrs. ...min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Retired - Formerly inspector

11. Industry or business

FATHER 12. Name Henry Gehrmann

13. Birthplace Germany

MOTHER 14. Maiden name Christine Meyer

15. Birthplace Germany

16. Informant Clinical Records

Address Vets. Adm. Fort Howard, Md.

17. Burial (Burial, cremation, or removal, which?) Date thereof 11/14/45 (month) (day) (year)

Cemetery or crematory Fairmount

Location Baltimore MD

18. Funeral director Milburn Lodge Inc

Address 1217 E Fort Ave

19. 11/12 19 45 C. M. Hewick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10/45 19... at 9:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/25/45 19... to 11/10/45 19...

and that I last saw h... (M.) alive on 11/10/45 19...

Immediate cause of death	DURATION
BRONCHOPNEUMONIA	
xxx Other conditions: Coronary arteriosclerotic heart disease	Unknown
xxx Hypertension, arterial	
Cerebral hemorrhage, old	
Other conditions Hemiplegia, left, old	
Arteriosclerosis, general	

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John T. Bracken Jr. Capt. A.U.S.
M. D. or other

Address FORT Howard MD. Date signed 11/11/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11506 P

CERTIFICATE OF DEATH

Reg. Dist. No. 3

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months
Hospital, institution, or street address where death occurred: Spring Grove State Hospital
How long in hospital or institution? 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore, Md. (If outside city or town limits, write RURAL and give nearest town)
Street No.: 820 Hollins Street (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: George German.

3. (b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: ----
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): July 1, 1877
8. AGE: Years 68, Months 4, Days 12. If less than one day ... hrs. ... min.
9. Birthplace: Baltimore County, Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Farm

FATHER
12. Name: George Israel German
13. Birthplace: Baltimore, County, Md.

MOTHER
14. Maiden name: Elizabeth Forman
15. Birthplace: Baltimore County, Md.

16. Informant: Hospital Records
Address: Catonsville, Balto. 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/14/45 (month) (day) (year)
Cemetery or crematory: Druid Ridge
Location: Pikesville Md.

18. Funeral director: William Cook Inc.
Address: 1217 St. Paul St

19. 11/13 1945 (Date rec'd by registrar) A. W. Hedrick D.M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 12 1945, at 12:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 12 1945, to Nov 12 1945 and that I last saw him ~~alive~~ dead on 11-12 1945

Immediate cause of death: Central nervous System Syphilis; Yrs which was the <u>immediate cause</u> of death. C.G.R.
Due to:
Due to:
Other conditions: Accidental Fracture of left Leg & Humerous; Struck by automobile, which had no bearing on his death. (Include pregnancy within 3 months of death) — DURATION: 3 mo.

Major findings of operations: None. Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: D. D. Caplan, M.D. M-E (M. D. or other)
Address: Reisterstown, Md. Date signed: 11-12-45

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (32)

Reg. Dist. No. 10797 74

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Baltimore
(b) City or town Middle River (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Golden Ring Rd.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) Life

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. Golden Ring Rd. (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** George Henry Giesen

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Anna Giesen

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug. 4th 1868

8. **AGE:** Years: 77 | Months: 2 | Days: 30 | If less than one day: ____ hr. ____ min.

9. Birthplace Missouri (Town, county, and state)

10. Usual occupation Truck farmer

11. Industry or business

FATHER
12. Name Geo. Giesen
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs. Anna Giesen
(b) Address Golden Ring Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 6 45 (month) (day) (year)
(c) Cemetery or crematory Zion Luth. Cem.
Location Balto Co. Md.

18 (a) Funeral director Langley Funeral Home
(b) Address 7401 Belair Rd.

19 (a) 11/3/45 (Date rec'd by registrar) (b) John M. Connelly Registrar

MEDICAL CERTIFICATION

20. Date of death Nov 3 1945, at 12 noon M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1945, to Nov 3 1945, and that I last saw him alive on Nov 3 1945.

	Duration
Immediate cause of death: Coronary Thrombosis	Sudden
Due to: Arteria Sclerotic-Cardio-Vascular disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. **Signature** Geo. M. Baumgardner M. D. or other
Address Balto 6 Md Date signed 11/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (946)

CERTIFICATE OF DEATH

10798 38
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County Balto.
City or town Loch Raven
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
Old Harford Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto
City or town Loch Raven
(If outside city or town limits, write RURAL and give nearest town)
Street No. Smith Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Henry Grammer

3.(b) Social Security Number 218-10-0022

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Helen P. Grammer
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 21st 1886

8. AGE: Years	Months	Days	If less than one day
59	5	17	..... hrs. ..... min.

9. Birthplace: Balto Co. Md.
(Town, county, and state)
10. Usual occupation: Sanitary Engineer
11. Industry or business: G. L. Martin Co
FATHER 12. Name: Geo. W. Grammer
13. Birthplace: Balto Co. Md
MOTHER 14. Maiden name: Annie Tyson
15. Birthplace: Balto Co. Md.
16. Informant: Mrs. W. G. Grammer
Address: Loch Raven
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11 12 45 (month) (day) (year)
Cemetery or crematory: Parkwood
Location: Balto Md.
18. Funeral director: Lassahn Funeral Home
Address: 7401 Belair Rd.
19. Nov. 10 1945 (Date rec'd by registrar) A. M. Bacon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 8, 1945, at 3:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Heart disease, coronary arteriosclerosis	11/8/45
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Rollin C. Hudson M.D. DHE
M. D. or other
Address: Towson Md. Date signed 11/8/45.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-6)

CERTIFICATE OF DEATH

10799 P

41

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Balto. Co.

City or town: Dundalk Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State: Md. County: Balto.

City or town: Dundalk Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rd # 3 - Box 281

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lonnie Greer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

6.(b) Name of husband or wife: Adeline Greer

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Aug. 30, 1880

8. AGE:

Years	Months	Days	If less than one day
65	3	23	hrs. min.

9. Birthplace: Charles Co., Md (Town, county, and state)

10. Usual occupation: Labor

11. Industry or business: Farmer

MOTHER FATHER

12. Name: David Greer

13. Birthplace: Md

MOTHER

14. Maiden name: Adeline Greer

15. Birthplace: Md

16. Informant: Adeline Greer

Address: Rd # 3 - Box 281 - Dundalk Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-25-45 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: A.A. Co. Md.

18. Funeral director: Charles R. Law

Address: 802 Madison Ave.

19. 11/24 19 45 (Date rec'd by registrar) G. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/23 19 45, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945 19 , to November 23 1945 and that I last saw him alive on November 23 1945

Immediate cause of death	Mitral Insufficiency	DURATION: Indefinite
Due to	Arterio-sclerosis	Indefinite
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. H. Thomas M.D. M.D. or other

Address: Glenn Sta. Md. Date signed 11/25/45

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 31

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2603 Poplar Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Larchmont (If outside city or town limits, write RURAL and give town)
(d) Street No. 2603 Poplar Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH OTT GREGORY

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
None	None	Female	White	Married

6 (b) Name of husband or wife Elwood Beach Gregory
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1867

8. AGE: Years	Months	Days	If less than one day
78	1	26	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Herman Ott
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothea Reubenstein
15. Birthplace Kiel, Germany

16 (a) Informant Mr. E. Beach Gregory
(b) Address 2603 Poplar Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 26 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23, 1945, at 2:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 22 1945 to Nov 23 1945 and that I last saw h.. alive on Nov 22 1945.

Immediate cause of death	Duration
Coronary occlusion	1 day.
Due to Arterio Sclerosis	?
Due to Hypertension	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter Dublett M. D.
Address 2220 Garrison Blvd (Physician signing)

VS 150

X NOV-25/45

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

10801

Reg. Dist. No. 35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Weisberg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Weisberg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: York Rd
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME Bertie M Griffin

3. (b) Social Security Number None

4. Sex: F | 5. Color or race: C | 6.(a) Single, married, widowed, or divorced: W-dowed

8.(b) Name of husband or wife: John R.

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 11 1863

8. AGE: Years: 80 | Months: 11 | Days: 15 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Balto Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Rowan Mayes
13. Birthplace: Balto. Co., Md.

MOTHER
14. Maiden name: Margaret Ann Mayes
15. Birthplace: Balto Co, Md.

18. Informant: Landon M. Brooks
Address: Sparks, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Nov. 29, 1945 (month) (day) (year)
Cemetery or crematory: Dessops
Location: Sparks, Maryland

18. Funeral director: Landon M. Brooks
Address: Sparks, Md.

19. Nov. 26 1945 (Date rec'd by registrar) Mrs Howard S. Markline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 26, 1945 at 8:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 20 1945, to Nov 26 1945 and that I last saw h.. alive on Nov 25 1945

Immediate cause of death	DURATION
Pneumonia	2 do
Due to: Broken Hip	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of Nov 20, 45
Where did injury occur? Parkton (City or town) Balto (County) Md (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury fall Injured at work?

23. SIGNATURE: Milton Bortner M.D.
M. D. or other
Address: White Hall Rd Date signed Nov 26, 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (925)

CERTIFICATE OF DEATH

10802

Reg. Dist. No. 37

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Texas

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 10 mo 6 da.

Hospital, institution, or street address where death occurred:

Baltimore County Home

How long in hospital or institution? 1 yr 10 mo. 6 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Sunnybrook

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME John Thomas Grass

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	—

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May. 3, 1864

8. AGE: Years	Months	Days	If less than one day
81	6	7	..... hrs. ..... min.

9. Birthplace Harford Co., Maryland.
(Town, county, and state)

10. Usual occupation Engineer

11. Industry or business

FATHER 12. Name John Grass

13. Birthplace Maryland

MOTHER 14. Maiden name Catherine Click

15. Birthplace Maryland.

16. Informant Welfare Board Register

Address Towson 4 Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 13 1945 (month) (day) (year)

Cemetery or crematory Watter's Mems. Harford Co.,

Location Forrettsville Md.

19. Funeral director Charles E. Grass

Address Benson Md.

19. Nov 16 1945 (Date rec'd by registrar) Wm J Schildwachter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1945, at 3 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4 1944, to 11/10 1945

and that I last saw h.. alive on 11/9 1945

Immediate cause of death	DURATION
Valvular Endocarditis	18 mo
Due to Arterio Sclerosis	
Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wilmer E. Ensor M.D
M. D. or other

Address Corbyville Md Date signed 11/10/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124)

10803 P

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 days

Hospital, institution, or street address where death occurred:

Veterans Administration, Fort Howard, Md.

How long in hospital or institution? 31 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: .....

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 220 N. Glover Street

(If rural, give LOCATION)

2.(a) If veteran, name war: World War

3.(a) FULL NAME: LESLIE LEE GROVE

3.(b) Social Security Number: 213-09-8017

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Ada Grove

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 29, 1898

8. AGE:	Years	Months	Days	If less than one day
	46	11	28	..... hrs. ..... min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: Typewriter mechanic

11. Industry or business: .....

FATHER

12. Name: William Grove

13. Birthplace: West Virginia

MOTHER

14. Maiden name: Wilma Smith

15. Birthplace: West Virginia

16. Informant: Clinical Records, Veterans Administration, Fort Howard, Maryland

Address .....

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/30/45 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery, Annapolis

Location: Blvd., Maryland

18. Funeral director: Lilly & Zeiler, Inc., 403 S.

Address Wolfe St., Baltimore, Md.

19. 11/28/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 27, 1945, at 7:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 27, 1945, to Nov. 27, 1945, and that I last saw him alive on November 27, 1945.

Immediate cause of death	DURATION
Cirrhosis of liver	Unknown
Due to:	.....
.....	.....
~~XXX~~ Other conditions:	.....
Pleural effusion, left	2 mos.
~~XXXXXXX~~ Hypertension, arterial	Unknown
Amputation, right leg	15 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: A. M. Balter

A. M. BALTER, LT. COL., CLIN. DIRECTOR

Address VAF, Fort Howard, Md. Date signed 11/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

10804 38

Reg. Diat. No.

P

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Owings Mills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yr 0 mo 22 da

Hospital, institution, or street address where death occurred:

Rosewood State Trng. School

How long in hospital or institution? 6 yr 0 mo 22 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Owings Mills

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rosewood St. Trng. School

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Evelyn Mary Handschuh

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: -----

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 7/25/32

8. AGE: Years	Months	Days	If less than one day
13	3	15	..... hrs. ..... min.

9. Birthplace: Baltimore, Baltimore, Md. (Town, county, and state)

10. Usual occupation: Inmate

11. Industry or business:

FATHER — 12. Name: Adam Handschuh

FATHER — 13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Naomi Wilson

MOTHER — 15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Naomi Handschuh

Address: 128 W. Burnett, Baltimore, Md.

17. Burial (Burial, cremation, or removal) Which? Date thereof 11/13/45 (month) (day) (year)

Cemetery or crematory: Parkwood Cem

Location: Parkville Balt Co

18. Funeral director: Wm Cook Inc

Address: 1217 N Paul St.

19. Nov 9 1945 (Date rec'd by registrar) A M Hedges Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 9 1945 at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 5 1945 to Nov. 9 1945 and that I last saw her alive on November 9 1945

Immediate cause of death	DURATION
Broncho-pneumonia and acute bronchitis	4 da
Due to: Serial epilepsy	
Due to:	
Other conditions: Deteriorated epileptic (Include pregnancy within 3 months of death)	Unknown

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: A G Butts M. D.

Address: Owings Mills, Md. Date signed: 11/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-Q)

10805

CERTIFICATE OF DEATH

Reg. Diat. No. 37

1. PLACE OF DEATH:

County: Baltimore County

City or town: Cockeysville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, Institution, or street address where death occurred: Masonic Home, Cockeysville Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5333 Falls Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Sda Jane Harp

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Wm. H. Harp

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 17th 1864

8. AGE: Years	Months	Days	If less than one day
81	10	22	..... hrs. ..... min.

9. Birthplace: Howard County Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: John W. Tipton

13. Birthplace: Howard County Md

MOTHER — 14. Maiden name: Mary Rebecca Jones

15. Birthplace: Howard County Md

16. Informant: Laura M. Schneider

Address: Masonic Home, Cockeysville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-10-45 (month) (day) (year)

Cemetery or crematory: Woodlawn Cemetary

Location

18. Funeral director: Geo. L. Boyer Jr.

Address: 1512 Hollins St

19. 11-9-45 (Date rec'd by registrar) Laura M. Schneider Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 8 1945, at 8:5 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940 to Nov 8 1945 and that I last saw her alive on Nov 7 1945

	DURATION
Immediate cause of death: Uremia	4 days.
Due to: Chronic Interstitial Nephritis	3 yrs
Due to: Generalized Arteriosclerosis	5 yrs
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please nnderline the cause to which death shonld be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wilbur F. Shellman M. D. or other

Address: 60 E. Biddle St Date signed 11/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

10806

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville 28, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs. 11 months

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 10 yrs. 11 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1224 N. Carolina St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Isabel F. H. Hauer

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife: William Deford Hauer

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 7, 1875

8. AGE:

Years	Months	Days	If less than one day
70	6	3	____ hrs. ____ min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: William Hopps
13. Birthplace: Ireland

MOTHER
14. Maiden name: Martha Louisa Chesher
15. Birthplace: Baltimore County, Md.

16. Informant: Hospital Records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/12/45 (month) (day) (year)

Cemetery or crematory: Druid Ridge Cemetery

Location: Pikesville

18. Funeral director: Henry W. Mears & Son

Address: 805 N. Calvert St.

19. 11/12 1945 (Date rec'd by registrar) A. W. Hedrick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 10 1945, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 10 1934, to Nov. 10 1945 and that I last saw h.e.r. alive on Nov. 10 1945

Immediate cause of death	DURATION
Myocardial Decompression	2 wks.
Due to: Hypertension Cardio-Vascular Renal Disease	Indefinite
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?): ____

Means of injury: ____ Injured at work?

23. SIGNATURE: Andrew Funk M.D. (M.D. or other)

Address: Spring Grove State Hosp. Date signed: Nov. 11, '45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

10867

CERTIFICATE OF DEATH

Reg. Dist. No. 41

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto
City or town Dundalk ?? ??
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1902 Maxwell Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Herget

3.(b) Social Security Number

4. Sex M
5. Color or race W.
6.(a) Single, married, widowed, or divorced Married.
6.(b) Name of husband or wife Eva Buyer.
6.(c) If alive, give age 84 years
7. Birth date of deceased (mo., day, yr.) July 9. 1858
8. AGE: Years 87 Months 4 Days 0 If less than one day ..... hrs. ..... min.
9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business
FATHER 12. Name John Herget
FATHER 13. Birthplace Germany ?
MOTHER 14. Maiden name Magdalene ?
MOTHER 15. Birthplace Germany.
16. Informant Mrs. Eva Herget.
Address 1902 Maxwell Ave
17. Burial Date thereof Nov 12, 45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Oak Lawn
Location Eastern Ave
18. Funeral director L. Heemann & Son
Address 32 S. Broadway.
19. Nov. 12 1945 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9th 1945, at 10 pm. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19....., to ..... 19.....
and that I last saw h..... alive on ..... 19.....
Immediate cause of death Coronary Occlusion — DURATION 30 min.
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. B. Davis M.D. M.D. or other
Asst. Dep. Med. Exam. - Balto Co.
Address Dundalk ?? Date signed 11/9/45

I

T

2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10808

Reg. Dist. No. .....

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months and 12 days
Hospital, institution, or street address where death occurred: Spring Grove State Hospital
How long in hospital or institution? 2 months and 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: .....
City or town: 2516 Park Heights Avenue
(If outside city or town limits, write RURAL and give nearest town)
Street No. Baltimore
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME: Dora Hieggby (Dorothea Hieggby)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William Hieggby (deceased)
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): August 15, 1864

8. AGE: Years	Months	Days	If less than one day
81	3	9	..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: None

FATHER
12. Name: John Dorfler
13. Birthplace: Germany

MOTHER
14. Maiden name: Margaret (last name?)
15. Birthplace: Germany

16. Informant: Hospital Records
Address: Catonsville, 28, Md.

17. Burial (Burial, cremation, or removal, which?) Date thereof: Nov. 28-45 (month) (day) (year)
Cemetery or crematory: Parkwood Mem.
Location: Taylor. Md.
18. Funeral director: Wm. A. Moran
Address: 340 E. Balto. St.

19. 11-27-45 (Date rec'd by registrar) 19..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 24 1945 at 3:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 12 1945 to November 24 1945
and that I last saw her alive on November 24 1945

Immediate cause of death	DURATION
Coronary occlusion	1 hour
Due to: Arteriosclerotic cardio-Vascular disease	Indeffn.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Henry C. A. Mead M.D.
M.D. or other
Address: Catonsville, Md. Date signed .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (937)

10809

P

CERTIFICATE OF DEATH

BALTIMORE CO.

Reg. Dist. No. 32

1. PLACE OF DEATH:
(Balto. Co.)
County Pikesville
City or town
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Pikesville
City or town
(If ontside city or town limits, write RURAL and give nearest town)
Street No. Campfield Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Annie Hittie

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec - 28 - 1866

8. AGE: Years 78 | Months 10 | Days 27 | If less than one day ..... hrs. ..... min.

9. Birthplace Somerset Co Pa.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Henry Hittie
13. Birthplace Unknown

MOTHER 14. Maiden name Amelia Muhlenberg
15. Birthplace Unknown

16. Informant Mrs. Maternal Aunt
Address Daughters Home - Campfield Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) 11 (day) 26 (year) 45

Cemetery or crematory St Pauls Cem
Location Wiltondale

18. Funeral director John C Miller Inc
Address 2445 E Oliver St

19. (Date rec'd by registrar) 11/26 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 19 45 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 2nd 19 45, to Nov. 24 19 45 and that I last saw h.e.r alive on Nov. 23rd 19 45

Immediate cause of death	DURATION
1) - Arterio - Sclerotic Heart Disease	10 yrs.
Due to - Acute Heart Failure	- 3 Days
Due to	
Other conditions - Chronic Infections Arthritis	15 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Earl L. Chambers M.D.
M. D. or other

Address 4108 Liberty Hts. Date signed 11/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

4108

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10810 P

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville 28, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 3mo 25days

Hospital, Institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 2 yrs 3 mo. 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: -

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 130 E. Montgomery St. (If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME: Maggie L. Hoff

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

B.(b) Name of husband or wife: Andrew Hoff

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 24, 1867

8. AGE: Years	Months	Days	If less than one day
78	2	17	..... hrs. Carc min.

9. Birthplace: Hesson, Germany (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: George Hoffman

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Dorothea Eischenraeder

MOTHER 15. Birthplace: Germany

18. Informant: Hospital Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/14/45 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: a. a. Co. Md.

18. Funeral director: William Cook Inc.

Address: 127 E. Paul St

19. 11/13 (Date rec'd by registrar) 1945 A. W. Hedrick D.M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 11, 1945, at 2:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16, 1945, to November 11, 1945 and that I last saw her alive on November 11, 1945

Immediate cause of death	DURATION
Carcinoma of the left breast with widespread metastases	Indef.
Due to:	
Due to:	
Other conditions: Senile dementia	3½ years

(Include pregnancy within 3 months of death)

Major findings of operations: Lt. mastectotomy: scirrhous carcinoma. Date of op. 8/20/43

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert E. Gardner M.D. M. D. or other

Address: Catonsville, 28, Md Date signed 11/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (13-F) Reg. Dist. No. 33

CERTIFICATE OF DEATH

10811

1. PLACE OF DEATH:
(a) County Baltimore
(b) City or town Reisterstown
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Int: Pleasant.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos 11 days.
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 120 N. Wolfe St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** Ida Hoffman

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1902

8. AGE: Years 42 | Months 10 | Days 16 | If less than one day ____hr. ____min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

FATHER
12. Name Louis Hoffman
13. Birthplace Russia

MOTHER
14. Maiden Name Anna Foreman
15. Birthplace Russia

16 (a) Informant Anna Hoffman (mother)
(b) Address 120 N. Wolfe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 6 1945 (month) (day) (year)
(c) Cemetery or crematory Adas Israel
Location North point & Germantheil

18 (a) Funeral director Jack Levin & Son
(b) Address 4424 E. Balto St.

19 (a) 11-6-45 (Date rec'd by registrar) (b) Mary B. Elvine Registrar

MEDICAL CERTIFICATION

20. Date of death November 6, 1945 at 4 05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 25, 1945, to Nov. 6, 1945, and that I last saw him alive on Nov. 6, 1945.

Immediate cause of death	Duration
Myocardial failure	
Due to Pulmonary Tuberculosis	10 months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underlins the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert J Shmai M.D. (M. D. or other)
Address Reisterstown Md Date signed Nov. 6, 1945

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (93-7)

10812 Reg. Dist. No. 43

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
(a) County Balto Co
(b) City or town Pikesville (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Phila Rd
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) Life

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Pikesville (If outside city or town limits, write RURAL and give town)
(d) Street No Phila Rd (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** Otillie Hoffmeister

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Chas H. Hoffmeister 6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June 20th 1878

8. AGE: Years 67 | Months 3 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county and state)

10. Usual occupation at home

11. Industry or business

FATHER 12. Name Herman Dehring
13. Birthplace Germany

MOTHER 14. Maiden Name —
15. Birthplace —

16 (a) Informant C. H. Hoffmeister
(b) Address Phila. Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 4 45 (month) (day) (year)
(c) Cemetery or crematory Zion Luth. Cem.
Location Balto. Co. Md.

18 (a) Funeral director Lansdale Funeral Home
(b) Address 7401 Belair Rd.

19 (a) Nov. 3-1945 (Date rec'd by registrar) (b) Mrs. G. L. Reifsnider Registrar

MEDICAL CERTIFICATION

20. Date of death Nov 1 1945, at 8:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945, to Nov 1 1945, and that I last saw him alive on Nov 1 1945.

Immediate cause of death	Duration
Coronary Thrombosis	Sudden
Due to Arterio-Sclerotic-Cardio Vascular disease	
Due to	
Other conditions Osteo-arthritis	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. M. Baumgardner M. D. or other
Address Balto Md Date signed 11/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 10813

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 days
Hospital, Institution, or street address where death occurred:
Veterans Administration, Ft. Howard, Md.
How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1102 West 40th Street
(If rural, give LOCATION)
2.(a) If veteran, name war: WWII

3.(a) FULL NAME: LEO E. HOLCOMB

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 19, 1925

8. AGE: Years	Months	Days	If less than one day
20	3	7	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Machinist
11. Industry or business:

FATHER
12. Name: Ralph Holcomb
13. Birthplace: Illinois

MOTHER
14. Maiden name: Madeline ?
15. Birthplace: New York

16. Informant: Clinical Records, Veterans Administration Facility, Ft. Howard, Md.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 29. 45 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Md.

18. Funeral director: A. Lee Oder
Address 4644 York Road, Baltimore, Md.

19. 11/27/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 26, 1945, at 4:40 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 14, 1945, to Nov. 26, 1945 and that I last saw him alive on Nov. 26, 1945

Immediate cause of death	DURATION
Rheumatic Heart Disease, cardiac enlargement and pericarditis with pericardial effusion	8 wks.
Due to: Rheumatic heart disease with aortic & mitral insufficiency	1 yr.
Due to:	
Other conditions: Pneumonia, lobar, right lower lobe	1 wk.
Acute rheumatic fever (Include pregnancy within 3 months of death)	8 wks.

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R. M. BALTER, LT. COL., CLIN. DIRECTOR
Address VAF, Ft. Howard, Md. Date signed 11/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10814

Reg. Dist. No. 40

1. PLACE OF DEATH:
County: Balto Co
City or town: Baldwin Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Baldwin Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Louise J. Hurline

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: the late David J. Hurline
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 1 - 1879

8. AGE: Years: 66 | Months: ✓ | Days: 1 | If less than one day: hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Chas Albright
13. Birthplace: Germany

MOTHER
14. Maiden name: Margaret Steinwedel
15. Birthplace: Germany

16. Informant: Nelson Hurline
Address: Baldwin Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 5-1945 (month) (day) (year)
Cemetery or crematory: Bleuheim Luther Cem
Location: Bleuheim Md.

18. Funeral director: Clarence E. Arthur
Address: Fork Md.

19. Nov. 2 1945 C. E. Arthur
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 2 1945, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1930, to Nov 2 1945
and that I last saw h[illegible] alive on Nov 2 1945

Immediate cause of death	DURATION
Cardiac Insufficiency	1 Year
Due to: Cardiac Asthma	23 Yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D., or other
Address: Baldwin Date signed: Nov 2-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

10815 P

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County Balto.

City or town Sparrows Point
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 518 East E. St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 27 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Balto.

City or town Sparrows Point Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 518 East E. St.
(If rurel give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Sallie M. Jackson.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	White	Married.

6 (b) Name of husband or wife Clifton R. Jackson.

6(c) If alive, give age 70 years

7. Birth data of deceased (mo., day, yr.) Jan 7 1886

8. AGE: Years	Months	Days	If less than one day
59	10	13	hrs. min.

9. Birthplace Harford Co Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Charles F. Ozen

13. Birthplace Md

MOTHER 14. Maiden name Sarah Ida Morgan

15. Birthplace Md

16. Informant Raymond Jackson

Address 2920 Dunsbury Rd Dundalk

17. Burial Date thereof 10/24/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oaklawn Cem.

Location Baltimore Co.

18. Funeral director Wm Cook Inc

Address 217 S Paul St

19. 11/24/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20 1945, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 20 1945, to 19, and that I last saw h alive on 19.

Immediate cause of death	DURATION
Coronary occlusion	1 week
Due to Hypertension	4 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Df operations

Df autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. McLearnon M.D.
Deputy Medical Examiner M. D. or other

Address Dundalk, Md Date signed 11-20-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (937)

10816

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:

County Balto.

City or town Granite

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Old Court Road

How long in hospital or institution? 2½ yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Granite

(If outside city or town limits, write RURAL and give nearest town)

Street No. Old Court Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William A Johnson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 27 1878

8. AGE: Years 66 | Months 11 | Days 23 | If less than one day ..... hrs. ..... min.

9. Birthplace Granite Balto Co (Town, county, and state)

10. Usual occupation Farm Laborer

11. Industry or business Farming

FATHER 12. Name Louis Johnson

FATHER 13. Birthplace Unknown

MOTHER 14. Maiden name unknown

MOTHER 15. Birthplace unknown

16. Informant John A Trail

Address Granite Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-22-45 (month) (day) (year)

Cemetery or crematory St. Thomas

Location Balto. Co.

18. Funeral director Harry Steer

Address Sykesville Md.

19. Nov. 20 1945 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1945, at 10-45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death ..... DURATION

Pulmonary Hemorrhage

Due to

Due to Cardio vascular disease

Other conditions sudden death

Injury

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE Geo. W. Kieffer Dep. Med. Exam. Balto Co. M. D. or other

Address 1010 Leadenhall Date signed 11-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10817 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Stevenson (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Stevenson Road
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 6 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Stevenson Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No.: Stevenson Road (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: Albert Charles Jones

3. (b) Social Security Number: 215-16-9080

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B (b) Name of husband or wife: Fannie B. Jones
6(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): November 4, 1899

8. AGE: Years	Months	Days	If less than one day
46	—	10	— hrs. — min.

9. Birthplace: Raspeburg, Balto. Co., Md. (Town, county, and state)
10. Usual occupation: Mechanic
11. Industry or business: U.S. Eng. Depot, Timonium, Md.
FATHER 12. Name: Albert E. Jones
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Myra Belle Jones
MOTHER 15. Birthplace: Maryland
16. Informant: Mrs. Fannie B. Jones
Address: Stevenson, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 16, 1945 (month) (day) (year)
Cemetery or crematory: Sater's Baptist Cemetery
Location: Brooklandville, Balto. Co. Md.
18. Funeral director: Jno. Burns' Sons
Address: Towson, Maryland
19. 11-16-45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 14, 1945, at 7a. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——, 19—, to Nov 14, 1945, and that I last saw him alive on 11-13-45, 19—.

Immediate cause of death	DURATION
Myocarditis	
Due to Nephritis	
Chronic	
Due to Cirrhosis	
Other conditions Pulmonary tuberculosis arrested	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Dt autopsy:

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John G. Safell M. D. or other
Address: Reisterstown, Md. Date signed: 11-14-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

10819

Reg. Dist. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Owings Mills, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 yrs 24 days

Hospital, institution, or street address where death occurred:
Rosewood Owings Mills, Md.

How long in hospital or institution? 23 yrs 24 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3211 Fairmount ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Jones, Margaret Lenora

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 16, 1915

8. AGE:

Years	Months	Days	If less than one day
30	6	28	hrs. min.

9. Birthplace: Norfolk Va.
(Town, county, and state)

10. Usual occupation: Inmate, Rosewood State

11. Industry or business: Training School

FATHER
12. Name: Edward W. Jones
13. Birthplace: Virginia

MOTHER
14. Maiden name: Margaret McDermott
15. Birthplace: Virginia

16. Informant: Institutional Records,

Address: Owings Mills, Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 15 1945 (month) (day) (year)

Cemetery or crematory: St Mary's

Location: Norfolk Va.

18. Funeral director: John E. Moran

Address: 3000 E Baltimore St

19. 11-14 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 14 Nov. 1945, at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 Nov 1945 to 14 Nov 1945 and that I last saw h... alive on 14 Nov. 1945

Immediate cause of death	DURATION
Bronchopneumonia	4 days
Due to: acute bronchitis	6 "
Due to:	
Due to:	
Other conditions: Luetic Disease (Syphilis)	Birth

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. S. Butler M. D. or other

Address: Owings Mills, Md Date signed: 11/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

10820

Reg. Dist. No. 33

1. PLACE OF DEATH:

County: Baltimore

City or town: Owings Mills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7mo 4 da

Hospital, institution, or street address where death occurred: Rosewood State Trng. School

How long in hospital or institution? 7mo 4 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Owings Mills

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rosewood St. Trng. School

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Chester Dallan Keane

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ----

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1/4/39

8. AGE: Years	Months	Days	If less than one day
6	10	5	..... hrs. ..... min.

9. Birthplace: Hagerstown, Washington, Md.

(Town, county, and state)

10. Usual occupation: Inmate

11. Industry or business

FATHER

12. Name: Stephen Keane

13. Birthplace: Highfield, Md.

MOTHER

14. Maiden name: Ruth Pryor

15. Birthplace: Highgate, Wash. Co., Md.

16. Informant: Mrs. J. H. Pryor (M.G.M)

Address: Highfield, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 11 1945 (month) (day) (year)

Cemetery or crematory: Bethel

Location: Md.

18. Funeral director: Walter G. Grove

Address: 278 Church St, Waynesboro Pa

19. Nov 9 1945 (Date rec'd by registrar) Dora B. Elins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 9 1945 at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 29 1945 to Nov. 9 1945 and that I last saw h. im alive on Nov. 9 1945

Immediate cause of death	DURATION
Broncho-pneumonia and acute bronchitis	5 da
Due to	
Due to	
Other conditions: Quadriplegic idiot	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: H. G. Butler M. D. or other

Address: Owings Mills, Md. Date signed: 11/9/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10821

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 1 mo., 3 days

Hospital, Institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 0 yrs., 1 mos., 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: 2204 W. Saratoga Street
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2204 W. Saratoga St., Balto., Md.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Emmanuel E. Keane

3. (b) Social Security Number: 218-07-6877

4. Sex: Male

5. Color or race: White ~~Color~~

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Elizabeth Keane

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): March 13, 1879

8. AGE: Years: 66 | Months: 8 | Days: 7 | If less than one day: ....hrs. ....min.

9. Birthplace: New York, New York
(Town, county, and state)

10. Usual occupation: Bar Tender

11. Industry or business:

FATHER
12. Name: Lawrence Keane
13. Birthplace: Ireland

MOTHER
14. Maiden name: Catherine O'Conner
15. Birthplace: Washington, D.C.

16. Informant: Emmanuel E. Keane

Address: 2204 W. Saratoga St., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 23, 1945 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: 3801 Frederick Rd., Balto., Md.

18. Funeral director: Phillip Herwig, Jr.

Address: 2024 Orleans St., Balto., Md.

19. Nov. 20, 1945 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 20, 1945 at 8:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 17, 1945 to Nov. 20, 1945 and that I last saw h...im alive on November 20, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 Mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: No operations Date of op.:

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Stewart S. Shaffer M.D. M.D. or other

Address: Mount Wilson, Md. Date signed: 11/20/45

Rec'd by Dr. E. E. Nichols 11-23-45

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

Correction of "Color" verified by phone to Mt. Wilson San. 3-19-46 MM.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.


RECEIVED
NOV 24 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10822

Reg. Dist. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 yrs., 10 mos., 4 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 34 yrs., 10 mos., 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4 West 24th Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Henry Kinear (Kinnear)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: none

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): unknown Jan. 12, 1883

8. AGE: Years	Months	Days	If less than one day
62 or 63	?10	13	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Engineer

11. Industry or business: Unknown

FATHER 12. Name: James C. Kinear

13. Birthplace: Unknown

MOTHER 14. Maiden name: Mary B. Gill

15. Birthplace: Unknown

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-29-45 (month) (day) (year)

Cemetery or crematory: GREENMOUNT CEM.

Location: BALTIMORE

18. Funeral director: WM. COOKINC.

Address: 1217 St. Paul

11-26-45 A.W. HEDRICH

19. (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25 19 45, at 5:45 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 21 19 11, to November 25 19 45

and that I last saw h... im ...alive on November 25 19 45

Immediate cause of death	DURATION
Chronic myocarditis and degeneration	Indefinite
Due to:	
Due to:	
Other conditions: Chronic pulmonary tuberculosis	about 5 yr

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: see above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Isadore Tuerk

23. SIGNATURE: Isadore Tuerk, M.D.

M. D. or other

Address: Catonsville-28, Md. Date signed: 11/25/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10)

CERTIFICATE OF DEATH

10823

Reg. Dist. No. 33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs 4 mo 29 da
Hospital, institution, or street address where death occurred:
Rosewood State Training School
How long in hospital or institution? 3 yrs, 4 mo. 29 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Somerset
City or town: Princess Anne
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Kirby, Harriett Rosemond

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	White	Single

6.(b) Name of husband or wife: none
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): July 2, 1936

8. AGE: Years	Months	Days	If less than one day
9	4	0	hrs. min.

9. Birthplace: Sussex Co., Delaware (Town, county, and state)
10. Usual occupation: Inmate; Rosewood State Training
11. Industry or business: School; Owings Mills, Md

FATHER
12. Name: Howard Kirby
13. Birthplace: Hudson, Ohio

MOTHER
14. Maiden name: Florence Packer
15. Birthplace: Hudson Ohio

16. Informant: Institutional Records; Rosewood
Address: State Training School; Owings Mills, Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof Nov 3 1945 (month) (day) (year)
Cemetery or crematory: Rosewood Cemetery
Location: Owings Mills.
18. Funeral director: E. Edwin Long
Address: Reisterstown Md

19. 11-3-, 1945 (Date rec'd by registrar) Nancy B. Elkins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 2 1945 at 1:15a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 30 1945, to Nov 2 1945 and that I last saw h.. alive on Nov 2 1945

Immediate cause of death	DURATION
Broncho-Pneumonia	2 da
Due to: Acute Bronchitis	4 da
Due to:	
Due to:	
Other conditions: Congenital organic Epileptic Idiot (Include pregnancy within 3 months of death)	Life

Major findings of operation: none
Date of op. none
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: none Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: George C. Medairy M. D (M. D. or other)
Address: Owings Mills, Md Date signed 11/3/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

10824

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:

County Baltimore

City or town Woodlawn (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

14 Gwynn Lake Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Baltimore

City or town Woodlawn (If outside city or town limits, write RURAL and give nearest town)

Street No. 14 Gwynn Lake Drive (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Edward Charles Klotsch

3.(b) Social Security Number 214-01-7529

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Bertha A. Kotsch

6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) November 11, 1890

8. AGE: Years	Months	Days	If less than one day
55	-	8	...hrs. ...min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation Plumbing Engineer

11. Industry or business H.E.Crook & Co.

FATHER 12. Name Edward C. Klotsch

13. Birthplace Germany

MOTHER 14. Maiden name Elizabeth Franke

15. Birthplace Germany

18. Informant Mrs. Bertha A. Klotsch

Address 14 Gwynn Lake Drive, Woodlawn

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 21, 1945 (month) (day) (year)

Cemetery or crematory Woodlawn Cemetery

Location Woodlawn, Md.

18. Funeral director J. Willis Lamoreau

Address 4510 Liberty Heights Ave.

19. 11-21 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19 1945 at 7.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/18/1945 to 11/19/1945 and that I last saw him alive on 11/19/1945

Immediate cause of death	DURATION
Cerebral hemorrhage.	9 hours
Due to Arterio Sclerosis	
Due to	
Other conditions Had at least 5 other cerebral accidents in past (Include pregnancy within 3 months of death)	none 8 weeks.

Major findings of operations ...Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. V. Harper M.D. M. D. or other

Address 5201 Gwynn Oak Ave. Date signed 11/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

10825

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Balto.

City or town: Parkville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 39 yrs.

Hospital, Institution, or street address where death occurred: 2715 Glendale Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Parkville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2715 Glendale Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: George C. Knobel

3. (b) Social Security Number: 217-07-5360A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Catherine E. Knobel

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 20th 1870

8. AGE: Years	Months	Days	If less than one day
75	7	19	..... hrs. ..... min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual occupation: Clothing cutter

11. Industry or business

FATHER — 12. Name: Geo. W. Knobel

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name:

MOTHER — 15. Birthplace: Germany

16. Informant: Mrs F. J. Buchheister

Address: 2715 Glendale Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/12/45 (month) (day) (year)

Cemetery or crematory: Oaklawn

Location: Balto. Md.

18. Funeral director: Lansdale Funeral Home

Address: 7401 Belair Rd.

19. Nov 10 1945 (Date rec'd by registrar) A. M. Bacon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 8 1945 at 11:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 5 1945 to November 8 1945 and that I last saw h.../...w alive on November 8 1945

	DURATION
Immediate cause of death: Respiratory Failure	48 hr.
Due to: Bronchial Pneumonia	2 weeks
Due to: General debility and Chronic heart failure	10 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Charles F. O'Donnell M. D. or other

Address: 7301 York Rd Date signed 11/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Lo 7168
7301 York Rd.

O'Donnell

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10826

Reg. Diat. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since July 5, 1943
Hospital, institution, or street address where death occurred: Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution? Since July 5, 1943

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Balto City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4608 Maunsell ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME (KOWALEWSKI)
Frank A Kowalewski

3. (b) Social Security Number
216-07-9995

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Eleanor Kowalewski
6.(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): Oct. 16, 1912

8. AGE: Years	Months	Days	If less than one day
33		24	hrs. min.

9. Birthplace: Baltimore Md
(Town, county, and state)
10. Usual occupation: Fish Cleaner
11. Industry or business:

FATHER
12. Name: John Kowalewski
13. Birthplace: Europe

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Personal History-Hispital Records
Address: Eudowood Sanatorium, Towson 4, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-13-45 (month) (day) (year)
Cemetery or crematory: Holy Rosary
Location: Balto. Co.
18. Funeral director: Wm. S. Fialkowski
Address: 2007 Eastern Ave

19. 11/10 1945 (Date rec'd by registrar) A. O. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 9 1945 at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5 1943 to Nov 9 1945
and that I last saw him alive on November 9 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: William A Bridges M. D. or other
Address: Towson 4 Maryland Date signed: 11-9-45

10827

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
1 Burkleigh Square
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1 Burkleigh Square
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Walter A. Kraft

3.(b) Social Security Number: 705-05-0183

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

B.(b) Name of husband or wife: Ella Jones Kraft
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 25, 1882

8. AGE: Years	Months	Days	If less than one day
63	7	28	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Supervisor of Freight Transp.
11. Industry or business: B & O RR

FATHER
12. Name: Frank M. Kraft
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Sarah Morse
15. Birthplace: Baltimore, Md.

16. Informant: Miss Margaret E. Kraft
Address: 1 Burkleigh Square, Towson

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 26, 1945 (month) (day) (year)
Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Md.
18. Funeral director: Miller Lamoreau
Address: 4510 Liberty Heights Ave.

19. Nov 24 19 1945 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 23 19 45 at 6.20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 21 AM 19 45 to Nov 23 PM 19 45 and that I last saw him alive on Nov 23rd 19 45

Immediate cause of death	DURATION
Nov. 23rd 1945	
Due to Coronary Thrombosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Daniel J. Lt. Thos. Jennifer M. D. or other
Address: 111 Alleghany Ave Towson, Md. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


RECEIVED
NOV 29 1945
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

16828

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville, 28, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years, 5 mo.s, 21 ds.
Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 2 yrs., 5 mo.s, 21 ds.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 806 Hollins Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Elize Kronenberg

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: August Kronenberg
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): January 21, 1861

8. AGE: Years	Months	Days	If less than one day
84	10	1	hrs. min.

9. Birthplace: Hessen, Germany
(Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business: Home
FATHER 12. Name: (First name?) Boette
13. Birthplace: Germany
MOTHER 14. Maiden name: Unknown
15. Birthplace: "
16. Informant: Hospital records
Address: Catonsville, 28, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 26-45 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Frederick Road.
18. Funeral director: Wm. H. Valentine
Address: 2326 Aiken St
19. 11/24 19 45 C. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 22 19 45, at 7:40 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Acute Cardiac failure	
Due to: Cardio vascular disease	
Due to: sudden death	
Other conditions: Injuries	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 3. A.M.
Accident, suicide, or homicide: Accident Date of: Nov. 22 45
Where did injury occur? Catonsville Baltimore Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Hospital
Means of injury: Fall on floor Injured at work? no

23. SIGNATURE: Geo. W. Kieffer Clerk Med. Rec. Spring Grove Hosp.
M. D. or other
Address: 1010 Leader Ave. Date signed: 11-22-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 20[illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto Co.
(b) Street address 1802 Walnut Ave
(c) Hospital or institution: Dundalk
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1802 Walnut Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Krysiak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 23-16

8. AGE: Years	Months	Days	If less than one day
28			hr. min.

9. Birthplace Buski Miss
(Town, county, and state)

10. Usual Occupation Assorter

11. Industry or business Crown Cork + Seal

FATHER
12. Name Frank Jaskulski
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Rose Byer
15. Birthplace Balto. Md.

16 (a) Informant James Krysiak
(b) Address 1802 Walnut St.

17 (a) Burial (b) Date thereof 11-19-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Balto. City

18 (a) Funeral director Wm. S. Filakowski
(b) Address 2007 Eastern Ave

19 (a) (b) Huntington Williams
(Date received by registrar) Registrar

NOV 16 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1945, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Diphtheria
Laryngitis + Tracheitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Eustace M.D.
Medical Examiner.
Date signed 11-15-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10830

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since July 21, 1945
Hospital, institution, or street address, where death occurred: Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution? Since July 21, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St Mary's
City or town: Fun wich - 3948 Wilsby ave Balto md
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Almira Helen Louden

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband ~~or wife~~: George H Louden
6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): November 26, 1873

8. AGE:	Years	Months	Days	If less than one day
	71	0	2	...hrs. ...min.

9. Birthplace: St Mary's County Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Charles Kirby
13. Birthplace: St Mary's County, md
MOTHER 14. Maiden name: Eliza Hayworth
15. Birthplace: St Mary's County Md
16. Informant: Personal History Hospital Records
Address: Eudowood Sanatorium Towson 4, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/3/45 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.
16. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 11/30 1945 Accepted (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 28 1945 at 8:20 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21 1945 to November 28 1945 and that I last saw her alive on November 28 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Since about January 1945
Due to	
Due to	
Other conditions: Diabetes Mellitus diagnosed after admission (Include pregnancy within 3 months of death)	

Major findings of operations: ...Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: William A Bridges M. D. or other
Address: Towson, 4 Maryland Date signed: 11-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

10831

CERTIFICATE OF DEATH

Reg. Diat. No. 38

1. PLACE OF DEATH:

County: Balto.

City or town: Parkville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Parkville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2815 Aldan Rd

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Margaret Carter Landes

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widowed

6.(b) Name of husband or wife: Kenny A. Landes

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Dec. 11. 1878

8. AGE:

Years	Months	Days	If less than one day
66	10	19	...hrs. ...min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: John C. Eddins

13. Birthplace: Virginia

MOTHER

14. Maiden name: Nancy Ellen ~~Lee~~ Monger

15. Birthplace: Virginia

16. Informant: Mrs. Doris Landes Lucas. (Daughter)

Address: 2815 Aldan Rd. - Parkville.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 5. 1945 (month) (day) (year)

Cemetery or crematory: Parkwood Cem.

Location: Balto. Co. Md.

18. Funeral director: Henry Sander & Sons Inc.

Address: North Ave & Broadway - Balto. 13. Md.

19. 11/3 1945 (Date rec'd by registrar) A. M. Bacon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 1. 1945 at 6.13 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13 1944, to Nov. 1 1945 and that I last saw her alive on Oct. 31 1945

	DURATION
Immediate cause of death: Chronic nephritis	about 4 years
Due to: The interstitial nephritis	
Due to: Hypertension	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A. M. Bacon M. D. or other

Address: 2810 Taylor Ave. Date signed: 11/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1407

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (463)

CERTIFICATE OF DEATH

10818

Reg. Dist. No.

9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
2613 Gwynndale Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2613 Gwynndale Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish-American War

3.(a) FULL NAME: Emil George Larson

3.(b) Social Security Number: 212-09-5738

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Gamalia E. Larson
6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): October 10, 1873

8. AGE:	Years	Months	Days	If less than one day
	72	1	18	...hrs. ...min.

9. Birthplace: Sweden (Town, county, and state)
10. Usual occupation: Retired Foreman
11. Industry or business: Continental Oil Co.

FATHER
12. Name: Mr. Larson
13. Birthplace: Sweden

MOTHER
14. Maiden name: Unknown
15. Birthplace: Sweden

16. Informant: Mrs. Gamalia E. Larson
Address: 2613 Gwynndale Ave., Woodlawn

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 1, 1945 (month) (day) (year)
Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Md.

18. Funeral director: Wallis Lamoreau
Address: 4510 Liberty Heights Ave.

19. 12-1 1945 (Date rec'd by registrar) O. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 28 1945, at 5.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June - 15th - 1945 to Nov. 28 1945 and that I last saw him alive on Nov. 28th 1945

Immediate cause of death	DURATION
(a) Carcinoma of Stomach	6 months
(b) Metastasis	
Due to	
Due to	
Other conditions -a) Arteri Sclerotic Heart Disease (b) Hypertension	3 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Earl L. Chambers M. D. or other
Address: 4108 Liberty Hgts Ave. Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9:2

10832

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH

County Balto.

City or town #1 Rivers View Rd-Dchester Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) Queens

State NY County Long Island

City or town Long Island

(If outside city or town limits, write RURAL and give nearest town)

Street No. 32-30 60th St Woodside

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John A. Lasby Lastey

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 65 | Months | Days | If less than one day hrs. min.

9. Birthplace Poland (Town, county, and state)

10. Usual occupation machinist

11. Industry or business Typographic

FATHER 12. Name unknown

13. Birthplace "

MOTHER 14. Maiden name "

15. Birthplace "

16. Informant A Tracy

Address New York

17. Burial & Removal Date receipt 12-4 45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Dunellen

Location Dunellen N J

18. Funeral director J C Hegi-substitution

Address Elliott city

19. 12/1/45 19 Miller
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-29 19 45, at 1.0 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-30 19 45, to 11-30 19 45.

and that I last saw ~~him~~ her ~~alive~~ on 11-30 19 45

Immediate cause of death Cardio-Vascular Disease — DURATION 10 min.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm D. D. Caples M. E.
M. D. or other

Address Reisterstown, Md Date signed 11-30-45

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

11511

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Balto.
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Dof 153 Back River Neck Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No. Dof 153 Back River Neck Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Helen Mae Lawson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

6.(b) Name of husband or wife James F. Lawson
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 12 - 1869

8. AGE: Years	Months	Days	If less than one day
76			hrs. min.

9. Birthplace Kentucky (Town, county, and state)
10. Usual occupation At Home
11. Industry or business

FATHER
12. Name ? Hall
13. Birthplace Kentucky

MOTHER
14. Maiden name Unknown
15. Birthplace —

16. Informant Olga Grace Lawson
Address Dof. 153 Back River Neck Rd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/12/45 (month) (day) (year)
Cemetery or crematory Arlington Meth.
Location Arlington Va.
18. Funeral director John J. Connelly
Address 418 Eastern Ave. Essex 21
19. 11/11/ 1945 John J. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9, 1945 at 2:0 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Cerebral Accident.	10 min
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. D. Davis M.D.
asst Dep. Med. Exam. Balto. M. D. or other
Address Courthouse Balto. Md. Date signed Nov. 10-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

10833

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:
County: Rockford Balt Co
City or town: Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balt Co
City or town: Rockford
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Harry Lemood

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Katherine E. Lemood
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 21 - 1870

8. AGE: Years 75 | Months 1 | Days 17 | If less than one day ..... hrs. ..... min.

9. Birthplace: Penna
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. Hebert Freichert
Address: Hyde Md.

17. (Burial, cremation, or removal. Which?) Buried
Date thereof: Nov 8 1945 (month) (day) (year)
Cemetery or crematory: Fork M. E. Cem.
Location: Fork Md.

18. Funeral director: Clarence E. Arthur
Address: Fork Md.

19. Nov. 6 1945 (Date rec'd by registrar)
G. E. Arthur Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 5 1945 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 8, 1945 to Nov. 5, 1945 and that I last saw him alive on Nov. 4, 1945

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to Coronary Sclerotic Heart Disease	2 Mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Clifford F. Hudson M.D.
M. D. or other
Address: Fork Md. Date signed 11/6/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44 — 10834

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 Days

Hospital, institution, or street address where death occurred: Vets. Adm. Hosp. Fort Howard, Maryland

How long in hospital or institution? 17 Days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 3907 Edgewood Road (If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: MAX LEVINE

3.(b) Social Security Number: 143-01-7836

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Edith K. Levine

6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): 2-2-1898

8. AGE:	Years	Months	Days	If less than one day
	47	9	6	...hrs. ...min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business

FATHER — 12. Name: Pinkess Levine

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Edith Dobbs

MOTHER — 15. Birthplace: Germany

16. Informant: Clinical Records, Vets. Adm. Hosp. Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-11-45 (month) (day) (year)

Cemetery or crematory: Hebrew Friendship Cem

Location:

18. Funeral director: Jack Lewis, Inc

Address: 1419 E. Balto St

19. 11/10 (Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 9, 1945 at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 23, 1945 to November 9, 1945 and that I last saw him alive on November 9, 1945

Immediate cause of death	DURATION
Rheumatic heart disease;	About
Myocardial damage, aortic & mitral valvular damage; cardiac dilatation, pulmonary edema.	10 Mos.
Due to	
Other conditions: Hypertension, arterial, systemic & Psychosis unclassified	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A. M. Balter

A. M. BALTER, LT.COL., M.C. CLIN. DIR.

Address: Fort Howard, Maryland Date signed: 11-9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

10835 P

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Parkville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or Institution:
2801 Taylor Ave.
Stay in hospital or Inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Parkville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 2801 Taylor Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Lilly HOWARD RANDOLPH LILLY

3. (b) Social Security Number: 220-03-0647

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife: --

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 5, 1919

8. AGE: Years	Months	Days	If less than one day
25	11	8	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: Western Union

FATHER
12. Name: George W. Lilly
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Isabel A. Turner
15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Isabel A. Lilly, mother
Address: 2801 Taylor Ave., Parkville

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/17/45 (month) (day) (year)
Cemetery or crematory: Mt. Olive Cem.
Location: Randallstown, Md.

18. Funeral director: WM. J. TICKNER & SONS,
Address: Balto., Md.

19. 11/15 1945 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 13th 1945, at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 12th 1945 to Nov 13 1945; and that I last saw him alive on Nov 12th 1945.

	DURATION
Immediate cause of death: Acute Congestive Cardiac Failure	30 minutes (½ hour)
Due to: Pulmonary Edema	1 1/2 days
Due to: Coronary Thrombosis	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy: No.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of:
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: None Injured at work?

23. SIGNATURE: L. L. Leedy M.D. (M. D. or other)
Address: 5106 Harford Rd Date signed: 11/13/45
Rollin E. Haldeman M.D. D.M.E.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(20)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

10836

★ Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Balto.
City or town: Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Ship yard
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 31 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rt 137 New Battle Grove
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: David Loukonen

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bertha Loukonen nee Lindqvist 6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): June 19 - 1887

8. AGE:

Years	Months	Days	If less than one day
58	5	7	...hrs. ...min.

9. Birthplace: Finland (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: Beth Shp. Co. Y. Pt.

FATHER
12. Name: Loukonen
13. Birthplace: Finland

MOTHER
14. Maiden name: Loukonen
15. Birthplace: Finland

16. Informant: Mrs. Bertha Loukonen
Address: Rt 137 New Battle Grove

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 30-45 (month) (day) (year)
Cemetery or crematory: Oak Lawn
Location: Eastern Ave.
18. Funeral director: John J. Connelly
Address: 418 Eastern Ave. Essex

19. Nov. 26 1945 John J. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 26 1945, at 11 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 26 1945, to ...19...
and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Coronary Occlusion	2 hrs.
Due to	Med.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
...Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. McLarnie M.D.
Deputy Medical Examiner
M. D. or other
Address: Dundalk, Md. Date signed: 11-29-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-C)

10837

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs., 4 mos., 4 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 2 yrs., 4 mos., 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 304 S. Exeter St., Balto., Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Edward Lozzi

3.(b) Social Security Number: 219-12-9759

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Anna Lozzi
6.(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): September 18, 1900

8. AGE: Years	Months	Days	If less than one day
45	1	16	...hrs. ...min.

9. Birthplace: Italy (Town, county, and state)
10. Usual occupation: Auto Mechanic
11. Industry or business:

FATHER
12. Name: Caspar Lozzi
13. Birthplace: Italy

MOTHER
14. Maiden name: May ?
15. Birthplace: Italy

16. Informant: Edward Lozzi
Address: 304 S. Exeter St., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 6, 1945 (month) (day) (year)
Cemetery or crematory: Holy Redeemer Cemetery
Location: 4430 Belair Rd., Balto., Md.

18. Funeral director: Frank Della Noce
Address: 52 N. Morley St., Balto., Md.

19. Nov. 3, 1945 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 3, 1945, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30, 1943, to Nov. 3, 1945 and that I last saw him alive on November 3, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 Yrs. 11 Mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: No operations
Date of op.:
Autopsy results: No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Stewart L. Shaffer M.D. (M. D. or other)
Address: Mount Wilson, Md. Date signed: 11/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (740)

CERTIFICATE OF DEATH

10838

Reg. Diat. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs., 4 mos., 8 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 15 yrs., 4 mos., 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1632 Gorsuch Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Andrew MacLaughlin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 14, 1870

8. AGE: Years	Months	Days	If less than one day
75	10	13	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Various jobs

FATHER — 12. Name: Matthew McLaughlin

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name: Margaret Carrol

MOTHER — 15. Birthplace: Ireland

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11, 28, 45. (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: Baltimore, Md.

18. Funeral director: Lilly & Fowler Inc.

Address: 4038 Old Frederick Rd. Baltimore Md

19. 11-28 18 45 Harry A. Miller (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 27 19 45 at 1030 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-27 19 45 to 19

and that I last saw h alive on 19

	DURATION
Immediate cause of death: Coronary occlusion	few hours
Due to: Paralysis Agitans	Years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Fred O Hodous M.D.

Acting Deputy medical Examiner

Address: Edgewood, Md. Date signed 11-27-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83

CERTIFICATE OF DEATH

10839

Reg. Dist. No. 37

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Sparks (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Sparks (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Clara Mc Cartha

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: David McCartha

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Feb. 15, 1896

8. AGE: Years	Months	Days	If less than one day
69	9	1	hrs. min.

9. Birthplace: Washington Co., Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: ? McConnell

13. Birthplace: Virginia

MOTHER 14. Maiden name: Clara C McConnell

15. Birthplace: Virginia

16. Informant: Mr Samuel A McCartha

Address: Sparks, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11 (month) 19 (day) 45 (year)

Cemetery or crematory: Middletown

Location: Middletown, Md.

18. Funeral director: London M. Brooks

Address: Sparks, Md.

19. Nov. 16- (Date rec'd by registrar) 19 45 Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 16 19 45, at 4:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 15 19 45, to November 16 19 45 and that I last saw her alive on November 15 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage, left	1 day
Due to: Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Elizabeth B. Averill M.D. M. D. or other

Address: Cockeysville, Md. Date signed 11-16-45

(14)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 472

CERTIFICATE OF DEATH

10840

★ Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto.

City or town Middle River

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Carroll Island Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Middle River

(If outside city or town limits, write RURAL and give nearest town)

Street No. Carroll Island Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME JOHN T. McCLELLAND

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Marie F. McClelland

B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1891

8. AGE:

Years	Months	Days	If less than one day
54	2	5	hrs. min.

9. Birthplace Balto. Co., Md. (Town, county, and state)

10. Usual occupation Automobile

11. Industry or business U.S. Govt.

FATHER

12. Name John T. McClelland

13. Birthplace Balto. Co., Md.

MOTHER

14. Maiden name Susan Earl

15. Birthplace Balto. Co., Md.

16. Informant Mrs. J. T. McClelland

Address Carroll Island Road

17. burial (Burial, cremation, or removal. Which?) Date thereof Nov. 17 1945 (month) (day) (year)

Cemetery or crematory Orems Methodist

Location Middle River, Md.

18. Funeral director Lansdale Funeral Home

Address 7401 Belair Road

19. Nov. 10 - 1945 (Date rec'd by registrar) John J. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9th, 1945 at 8:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 3 1945, to Nov 9 1945

and that I last saw him alive on Nov 5 1945

Immediate cause of death	DURATION
Carcinoma of Lung	6 mo
Due to	
Due to	
Other conditions	

(Includo pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Emory McKenney M. D. or other

Address Emory Md Date signed 11/10/45

VS A15

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

414 1/2
Eastern Ave.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22d)

10841

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County: Baltimore
City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13yr 9mo 18da
Hospital, institution, or street address where death occurred:
Rosewood St. Training School
How long in hospital or institution? 13yr 9mo 18da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rosewood State Training School
(If rural, give LOCATION)
2.(a) If veteran, name war: ----

3.(a) FULL NAME: Dorothy McConnell

3.(b) Social Security Number: ----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: -----
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): 10/25/22

8. AGE: Years	Months	Days	If less than one day
23	1	4	..... hrs. ..... min.

9. Birthplace: Baltimore, Baltimore, Md. (Town, county, and state)
10. Usual occupation: Inmate
11. Industry or business: ----

FATHER
12. Name: William T. McConnell
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Augusta E. McNeave
15. Birthplace: Ruxton, Md.

16. Informant: Institutional records
Address: Rosewood St. Training School

17. Burial (Burial, cremation, or removal, Which?) Date thereof Dec 2nd (month) (day) (year)
Cemetery or crematory: Baltimore Cem
Location: City
18. Funeral director: Hillsick Funeral Home
Address: 2008 Aisquith St
19. 12-1- 1945 A M Hildreth Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 29 1945, at 3:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1 1938 to Nov. 29 1945 and that I last saw her alive on November 29 1945

Immediate cause of death	DURATION
Acute bronchitis with Cardiac decompensation	17 da.
Due to Chronic myocarditis and endocarditis with Cardiac hypertrophy	13 yrs + 9 mos 19 dys
Due to Rheumatic fever (History — Baltimore Gen'l Hosp.)	(Jan–Mar. 1930)
Other conditions Post-encephalitis with athetoid movements	13 yrs 9 mo 18 da +

(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Isabel H. McClellan M.D.
M. D. or other
Address: Owings Mills, Md. Date signed 11/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10842

(107)

CERTIFICATE OF DEATH

Reg. Diat. No. 34

1. PLACE OF DEATH:

County: Baltimore County

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, Institution, or street address where death occurred: Harlem Lodge Employee

How long in hospital or institution? 5-½ yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balt

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. P.G. Carlin's Lane

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Barney McCormick

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1860

8. AGE: Years: 85? Months: Days: If less than one day: hrs. min.

8. Birthplace: England (Town, county, and state)

10. Usual occupation: Gardener

11. Industry or business:

FATHER — 12. Name: Not Known

13. Birthplace: " "

MOTHER — 14. Maiden name: " "

15. Birthplace: " "

16. Informant: Jesse Sundry

Address: Catonsville

17. Buried (Burial, cremation, or removal. Which?) Date thereof 11-15-45 (month) (day) (year)

Cemetery or crematory: Cathedral

Location: Baltimore Md

18. Funeral director: Geo. A. Tuley

Address: Catonsville Md

19. 11/14/1945 (Date rec'd by registrar) J. Carroll Mummert M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 13 1945 at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1944, to November 1945

and that I last saw him alive on Nov. 13-1945

Immediate cause of death	DURATION
Cardiac decompensation acute	2 hrs.
Due to: Bronchopneumonia	48 hrs.
Due to:	
Other conditions: Arteriosclerosis generalized	years.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arthur V. Mitchell M.D. M. D. or other

Address: Harlem Lodge Catonsville, Md. Date signed NOV. 13, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

10843

CERTIFICATE OF DEATH

Reg. Diat. No. 37

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Cockeysville. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 years.

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Cockeysville. (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Margaret Merriken

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6.(b) Name of husband or wife: Peter L. Merriken. 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 3, 1852.

8. AGE: Years: 93 | Months: 7 | Days: 10 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Freeland, Md. (Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business: Own home.

FATHER 12. Name: Unknown

13. Birthplace: "

MOTHER 14. Maiden name: Unknown

15. Birthplace: "

16. Informant: Mrs. Maxwell Sacra

Address: Corbeysville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 16 1945 (month) (day) (year)

Cemetery or crematory: Mt. Zion Cemetery

Location: Fyeglade, Md

1B. Funeral director: Jacob Harbaugh

Address: New Freedom, Pa.

19. Nov 13 1945 (Date rec'd by registrar) Minnie C. Snook Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 13 1945 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 12 1945 to November 13 1945 and that I last saw h. alive on November 12 1945

	DURATION
Immediate cause of death: Arteriosclerotic heart disease	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Elizabeth B. Atwell M.D. M. D. or other

Address: Cockeysville, Md. Date signed Nov 13, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

10844

CERTIFICATE OF DEATH

Reg. Dist. No. 34

1. PLACE OF DEATH:
County: Baltimore
City or town: Upperco (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Upperco (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Robert E Mengman

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widower

8.(b) Name of ~~husband~~ or wife: Rosella Annacost
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 29 - 1945 1863

8. AGE:

Years	Months	Days	If less than one day
82	8	—	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Retired farmer
11. Industry or business
FATHER 12. Name: Elisha Mengman
13. Birthplace: Maryland
MOTHER 14. Maiden name: Sarah Baltrides
15. Birthplace: Maryland
16. Informant: Julia Mengman
Address: Hampstead Md (R.D)
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 2-45 (month) (day) (year)
Cemetery or crematory: Grace
Location: Balto Co. Md
18. Funeral director: Edw C Tipton
Address: Hampstead Md.
19. Dec 1 1945 (Date rec'd by registrar) B E Fridinger M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 29 1945, at 3 30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 25 1945 to Nov 29 1945 and that I last saw h— alive on November 29 1945
Immediate cause of death: Cerebral Hemorrhage — DURATION 4 hrs
Due to: Arterio-Sclerotic Cardio-Renal Disease. — DURATION November
Due to: — DURATION
Other conditions: — DURATION
(Include pregnancy within 3 months of death)
Major findings of operations: — Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE: Joseph E. Bunk M.D. M. D. or other
Address: Hampstead Md. Date signed 11-30-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (191-a)

CERTIFICATE OF DEATH

10845 P

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville 28, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 4 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: —

City or town: Baltimore Co.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 617 Bartlett Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: Joseph Messick

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 17, 1869

8. AGE: Years	Months	Days	If less than one day
76	7	25	hrs. min.

9. Birthplace: Havre de Grace, Md. (Town, county, and state)

10. Usual occupation: Plumbers Helper

11. Industry or business

FATHER — 12. Name: James Messick

13. Birthplace: Md.

MOTHER — 14. Maiden name: Mary A. Murphy

15. Birthplace: Ireland

16. Informant: Hospital Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/11/45 (month) (day) (year)

Cemetery or crematory: Patapsco

Location: Catonsville Md.

18. Funeral director: Wilson Cook Inc by

Address: 1214 St Paul St Baltimore Md.

19. 11/12 1945 (Date rec'd by registrar) A. M. Kelsick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 11 1945, at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11 1945, to Nov. 11 1945

and that I last saw h.. alive on Nov. 11, 1945

Immediate cause of death	DURATION
Hypertension Cardio-Vascular-Renal Disease	Indefinite
Due to	
Due to	
Other conditions: Rectal Hemorrhage; Cause Und.	9 days

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Theodore Turck, M. D. (M. D. or other)

Address: Spring Grove State Hosp. Date signed: Nov. 13 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-D)

CERTIFICATE OF DEATH

10846

Reg. Dist. No. 30

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville-28 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 2028 Old Frederick Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Catonsville-28 (If outside city or town limits, write RURAL and give nearest town)

Street No.: 2028 Old Frederick Road (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Anna F. Meyer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Herman F. A. Meyer

6.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): June 6. 1864

8. AGE:

Years	Months	Days	If less than one day
81	5	0	hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business

FATHER 12. Name: Victor Neuenhahn

13. Birthplace: Germany

MOTHER 14. Maiden name: Marie Krach

15. Birthplace: Germany

16. Informant: Herman W. Meyer

Address: 2028 Old Frederick Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 9. 1945 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: 3801 Frederick Road

18. Funeral director: Mrs. Mue. John W. Teufel & Son

Address: 801 W. Fayette St

19. 6 8 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 6, 1945 at 11:55 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 7 1945, to Nov. 7 1945 and that I last saw h alive on not seen alive 19

Immediate cause of death	DURATION
Cardio-Vascular Disease	5 min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. D. Eagles, M.D. M. D. or other

Address: 6 Hanover Rd., Reis. Md. Date signed: 11-7-'45

10847

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:
County Baltimore
City or town Randallstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Randallstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. Liberty Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Gertrude Megan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife John Thomas Megan
6.(c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) August 23, 1867

8. AGE: Years	Months	Days	If less than one day
78	3	2	hrs. min.

9. Birthplace Baltimore County, Maryland
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name John Greenwalt
13. Birthplace Germany

MOTHER
14. Maiden name Anna Marie Holtzner
15. Birthplace German

16. Informant John Thomas Megan
Address Randallstown - Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov-30-45 (month) (day) (year)
Cemetery or crematory Holy Family
Location Harrisonville, Maryland
18. Funeral director Frank H. Nuell
Address Pikesville, Maryland
19. Nov 28 1945 Wm. E. Martin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1945, at 9:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1937, to Nov. 27 1945
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Carcinoma of stomach	3
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm. E. Martin M. D. or other
Address Randallstown Date signed Nov. 28, 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

CERTIFICATE OF DEATH

P

10848 37

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Balto.
City or town: Parkville.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
3003 Balder ave
How long in hospital or institution? 6 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Parkville ?
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3003 Baldeave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Joseph Minnick
3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single.

6.(b) Name of husband or wife
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Nov 11/1880.

8. AGE:

Years	Months	Days	If less than one day
65	-	-	...hrs. ...min.

9. Birthplace: Balto. City.
(Town, county, and state)
10. Usual occupation: machine operator.
11. Industry or business: Retired.
FATHER 12. Name: Joseph Henry Minnick
13. Birthplace: Baltimore Md.
MOTHER 14. Maiden name: Margaret Jane O'Brien
15. Birthplace: Baltimore Md
16. Informant: Theresa Minnick (Sister)
Address: 3003 Balder Ave. Parkville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/14/45 (month) (day) (year)
Cemetery or crematory: Holy Redeemer
Location: Belair Rd., Balto. Md.
18. Funeral director: George J. Ruth Inc.
Address: 1735 Hoffford Ave. Balto Md
19. 11-13-1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 11, 1945; at 4 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 11, 1945, to ...19...
and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Coronary occlusion	Months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury. Injured at work?

23. SIGNATURE: J. McCarmine, M.D.
M. D. or other
Address: Deputy Medical Examiner Brooklyn Md. Date signed: 11/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10849 44

1. PLACE OF DEATH:
County: Balto.
City or town: East
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: East
(If outside city or town limits, write RURAL and give nearest town)
Street No. 296 Stillwater Cove.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Vola M. Moorefield

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 6 - 1896

8. AGE: Years	Months	Days	If less than one day
49	6	24	..... hrs. ..... min.

9. Birthplace: Balto.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Thomas N. Benson
13. Birthplace: Balto.
MOTHER 14. Maiden name: Sarah J. Thorney
15. Birthplace: Balto.
16. Informant: Mrs. Moorefield
Address: 296 Stillwater Cove East
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 3 - 45 (month) (day) (year)
Cemetery or crematory: Moreland Memorial Park
Location: Taylor Ave.
18. Funeral director: John G. Connelly
Address: 418 Eastern Ave. East
19. Dec 2 (Date rec'd by registrar) 19 45 John H. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 30th 1945, at 2.10 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2 19 45, to Nov 30 19 45
and that I last saw h[illegible] alive on Nov. 30 19 45

Immediate cause of death	DURATION
Intestinal Obstruction	
Due to: Carcinomatosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operation: Carcinoma of Rectum. Date of op.
Autopsy, results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. A. Jacobs M.D. (M. D. or other)
Address: 617 North St Rd Date signed 12/7/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 446

10850

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:

County Baltimore

City or town Rockdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr 6 mos

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Rockdale

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2503 Rockdale

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Rev. Melvin N. Morris

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Elizabeth Decker Morris

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 6th 1917

8. AGE: Years	Months	Days	If less than one day
28	3	27	..... hrs. ..... min.

9. Birthplace Phila Pa.

(Town, county, and state)

10. Usual occupation Student

11. Industry or business Acting Minister

FATHER 12. Name Leo J. Morris

13. Birthplace England

MOTHER 14. Maiden name Virginia Calhoun

15. Birthplace Texas

16. Informant Mrs Melvin N. Morris

Address 2503 Rolling Road Rockdale

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-3-45 (month) (day) (year)

Cemetery or crematory Druid Ridge

Location Pikesville, Md.

18. Funeral director Lorenz Byers

Address 5005 Park Heights Ave 15

19. 12/3 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30 19 45, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to Nov. 25 19 45

and that I last saw him alive on Nov. 25 19 45

Immediate cause of death	Secondary	DURATION
	Cachexia	
Due to	Hodgkins Disease	
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Arthur W Kac M. D. or other

Address 11 E. Chase St Date signed 12/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1030

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10851

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 days

Hospital, institution, or street address where death occurred:
Veterans Administration, Ft. Howard, Md.

How long in hospital or institution? 41 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1041 Cathedral Street
(If rural, give LOCATION)

2.(a) If veteran, name war: World War V

3.(a) FULL NAME
DANIEL P. MURNANE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 2, 1887

8. AGE: Years 58 | Months 9 | Days 26 | If less than one day: hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Patrick Murnane
13. Birthplace: Ireland

MOTHER
14. Maiden name: Alice Enright
15. Birthplace: Ireland

16. Informant: Clinical Records, Veterans Administration, Fort Howard, Maryland
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 1 1945 (mouth) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Frederick Road, Balto., Md.

18. Funeral director: A. Lee Oder

Address: 4644 York Road, Baltimore, Md.

19. 12/3 1945 John W. Kehrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 28 1945, at 5:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 17 1945, to Nov. 28 1945 and that I last saw him alive on November 28 1945

Immediate cause of death	DURATION
CORONARY OCCLUSION	1 day
Due to:	
Other conditions:	
~~xxx~~ Rheumatoid arthritis, acute	2 mos.
Toxemia, acute, cause undet.	2 mos.
~~xxxxxxx~~ Pulmonary fibrosis, right upper lobe	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A M Balter M. D., Other

A. M. BALTER, LT. COL., CLINICAL DIRECTOR

Address: VAF, Fort Howard, Md. Date signed 11/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

10852 P

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:
County Baltimore County
City or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred:
2649 Purnell Drive
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore Co.
City or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2649 Purnell Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George Emory Murphy

3.(b) Social Security Number 705-12-1275

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 15 1883

8. AGE: Years 62 | Months 3 | Days 3 | If less than one day ..... hrs. ..... min.

9. Birthplace Jamsville Frederick Co Md
(Town, county, and state)

10. Usual occupation Boiler Maker

11. Industry or business Locomotive Shops B & O

FATHER
12. Name Franck A. Murphy
13. Birthplace Frederick Co Maryland

MOTHER
14. Maiden name Ella V. Crawford
15. Birthplace Frederick Co Maryland

18. Informant Mr. Lloyd L. Murphy
Address 2649 Purnell Drive

17. Burial Date thereof 11/21/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Loudon Park Cem.

Location Baltimore, Md.

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. Nov. 19 1945 C W Tedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 1945, at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1 1945, to Nov. 18 1945
and that I last saw h~~im~~ alive on Nov. 18 1945

Immediate cause of death	DURATION
Coronary Thrombosis	14½ hrs.
Due to Arterio-sclerotic Cardio vascular Disease	1 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations No operation Date of op.

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joshua H Armacost MD
M. D. ~~coroner~~

Address 6419 Windsor Mill Rd Date signed Nov 19
Baltimore-7 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10853 P

Reg. Diat. No. 44

1. PLACE OF DEATH:
County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 21 days
Hospital, institution, or street address where death occurred:
Veterans Administration, Ft. Howard, Md.
How long in hospital or institution? 1 year, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5003 Govans Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war Spanish-American ✓

3.(a) FULL NAME CHARLES JOSEPH O'BRIEN

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 13, 1870

8. AGE: Years	Months	Days	If less than one day
75	3	14	..... hrs. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation Interior decorator

11. Industry or business

FATHER 12. Name Patrick O'Brien
13. Birthplace Ireland

MOTHER 14. Maiden name Frances A. Fink
15. Birthplace Maryland

16. Informant Clinical Records, Veterans Administration
Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/30/45 (month) (day) (year)

Cemetery or crematory St. Mary's Cemetery, Govans,
Location Maryland

18. Funeral director William J. Tickner & Sons
Address Penna. & North Aves. Balto. Md.

19. 11/28 19 45 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 19 45, at 6:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 6 19 44, to Nov. 27 19 45 and that I last saw him alive on November 27 19 45

Immediate cause of death	DURATION
Bleeding peptic ulcer	1 mo.
Due to Chr. duodenal & gastric ulcers	1 yr. 8 mo
Other conditions: Arrested chronic pulmonary tuberculosis	Undet.
Hypertrophic spondylitis	"
Cerebral arteriosclerosis	"
Coronary heart disease	"

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm. Balter
WM. BALTER, LT. COL., CLINICAL DIRECTOR
Address VAF, Fort Howard, Md. Date signed 11/27/45

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164a)

CERTIFICATE OF DEATH

10854 P

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore (6072 Falls Road
City or town Mt. Washington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Mt. Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6072 Falls Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Frederick Pahl

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married.

6.(b) Name of husband or wife Mary E. Pahl.
6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) October 15, 1880

8. AGE: Years	Months	Days	If less than one day
65			....hrs. ....min.

9. Birthplace Maryland.
(Town, county, and state)
10. Usual occupation Watchman
11. Industry or business Catalyst Research Corp.

FATHER
12. Name Henry Pahl
13. Birthplace Maryland.

MOTHER
14. Maiden name Mary ?
15. Birthplace Maryland.

16. Informant Mary E. Pahl.
Address 6072 Falls Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 23/45 (month) (day) (year)
Cemetery or crematory Woodlawn
Location
19. Funeral director Cunnowell & Donovan.
Address 3615-17 Chestnut Ave.

19. 11-20 1945 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1945, at 11 45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....
and that I last saw h... alive on ....19....

	DURATION
Immediate cause of death Strangulation, suicide	11/19/45
Due to Despondency & depression	
from ill health	2 or 3 mo.
Due to Gastric ulcers	2 or 3 mo.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Suicide Date of Nov. 19, 1945.
Where did injury occur? Mt Washington (City or town) Balto (County) Md. (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Hanging - suicide Injured at work?

23. SIGNATURE Collin L. Hudson M.D. M.E.
M. D. or other
Address Towson 4 Md Date signed 11/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42)

CERTIFICATE OF DEATH

P 10855

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Balto.
City or town: Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
7315 Geise Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 7315 Geise Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ELIJAH PARRISH

3.(b) Social Security Number: 216-09-7419

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Jennie T. Parrish
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 15, 1879

8. AGE: Years	Months	Days	If less than one day
66	8	28	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation
11. Industry or business: Crown Cork & Seal Co.

FATHER
12. Name: John Parrish
13. Birthplace: Unknown

MOTHER
14. Maiden name: "
15. Birthplace: "

16. Informant: Mrs. Jennie T. Parrish
Address: 7315 Geise Ave., Sparrows Pt., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/16/45 (month) (day) (year)
Cemetery or crematory: Western Cem.
Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 11/15 45 (Date rec'd by registrar) A. C. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 13, 45 at 5:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19 45 to Nov 13 19 45 and that I last saw h[illegible] alive on November 1 19 45

Immediate cause of death	DURATION
Carcinoma of Lung	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: 520 D St. Sp Pg Date signed: Nov 14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 44

Law No. 100 FEB 7 1946

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dundalk
(c) Hospital or institution: Sofonski Farm
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. Sofonski Farm
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Patterson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
41			hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Sofonski Farm

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Balto Co. Police Dept.
(b) Address Towson, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 28-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Ba. Co.

18 (a) Funeral director John G. Connelly
(b) Address 418 Eastern Ave. Essex

19 (a) Nov. 28 45 (b) J. G. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 1945, at 5:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab Wound of Neck

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury November 23, 1945 5-6 P.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work? No
(d) Means of injury Stabbing

23. Signature Robert L. Gretsch M.D.
Medical Examiner.
Date signed 11-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore Md

10857

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:

County Balto.

City or town 8007 Sheeley Drive - Balto 7, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 mos.

Hospital, Institution, or street address where death occurred:
at Home.

How long in hospital or institution? Home.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Balto.

City or town Balto.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8007 Sheeley Drive - Balto 7, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war No.

3.(a) FULL NAME Samuel Arthur Patterson

3.(b) Social Security Number 705-05-2696

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife Gertrude B. Patterson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1899

8. AGE: Years	Months	Days	If less than one day
46	0	7	..... hrs. ..... min.

9. Birthplace Carroll Co., Md.
(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business B. & O. R. R.

FATHER 12. Name Joshua Patterson

13. Birthplace Carroll Co., Md.

MOTHER 14. Maiden name Clara B. Deeds

15. Birthplace Carroll Co., Md.

16. Informant Mrs. Gertrude Patterson

Address 8007 Sheeley Drive

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/14/45 (month) (day) (year)

Cemetery or crematory Woodlawn Cem.

Location Woodlawn, Md.

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. 11/14 (Date rec'd by registrar) 19 45 Alice Kelbrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-11 19 45, at 12:20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-11-'45 19..... to 11-11-'45 19.....
and that I last saw him alive on 11-11-'45 19.....

Immediate cause of death	DURATION
Heart Block	20 min
Due to	
Due to	
Other conditions Fell from step ladder	20 min
abrasions of R side of face	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE D. D. Caples, M.D M. E.
M. D. or other

Address Reisterstown, Md. Date signed 11-11-'45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Wm Zichmer
N.-Penn Ave.
Balto 17, Md.

Roslyn 9399.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-D)

CERTIFICATE OF DEATH

10858

Reg. Dist. No. .....

1. PLACE OF DEATH

County Baltimore

City or town Govans Baltimore 12; Haddon Ave.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 35 yrs

Hospital, institution, or street address where death occurred: at home

How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Govans Woodbrook

(If outside city or town limits, write RURAL and give nearest town)

Street No. Haddon Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME William Julius Pohlman

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife Single

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) About - 1853

8. AGE:	Years	Months	Days	If less than one day
abt	92			hrs. min.

9. Birthplace probably Balto. Md. (Town, county, and state)

10. Usual occupation retired

11. Industry or business .....

FATHER — 12. Name Pohlman

FATHER — 13. Birthplace Germany

MOTHER — 14. Maiden name Louisa Augusta Pohlmann

MOTHER — 15. Birthplace Germany

16. Informant Miss Pohlman (Sister)

Address Woodbrook - Balto 12

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec-3-45 (month) (day) (year)

Cemetery or crematory Loudon Park

Location Baltimore

18. Funeral director Stewart Mortuary Co.

Address 108 W. York - Balto Md

19. 12 - 1 1945 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 1945, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Approx. None 19.. to .. 19..

and that I last saw h.. alive on .. 19..

Immediate cause of death	DURATION
Heart disease, chronic myocarditis	Unk
Due to Senile changes	Unk
Due to Arteriosclerosis	Unk
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Rollin C. Hudson M.D. DME

M. D. or other

Address Towson 4 Md Date signed 11/30/45.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-C

CERTIFICATE OF DEATH

10859

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 Days

Hospital, Institution, or street address where death occurred: Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 21 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pennsylvania County:

City or town: Shinglehouse (If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. (If rural, give LOCATION)

2.(a) If veteran, name war: PTE

3.(a) FULL NAME: ERNEST CHARLES PUFF

3.(b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Reba Puff

6.(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): 10-4-17

8. AGE:

Years	Months	Days	If less than one day
28	1	12	hrs. min.

9. Birthplace: Franklinville, N.Y. (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business:

FATHER — 12. Name: August Puff

13. Birthplace: New York

MOTHER — 14. Maiden name: Esther Coleman

15. Birthplace: New York

16. Informant: Clinical Record, Vets. Adm. Hosp. Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-21-45 (month) (day) (year)

Cemetery or crematory: Olean

Location: Olean N.Y.

18. Funeral director: Olean Funeral Home Inc

Address: 644 York Road

19. 11/18/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 17, 1945, at 2:05 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 27, 1945, to November 17, 1945 and that I last saw him alive on November 17, 1945

Immediate cause of death: Meningitis tuberculous — DURATION: 10 Days

Due to: Tuberculosis, chr. pul. far. advanced active — DURATION: plus 5 Yrs.

Due to: —

Other conditions: Otitis media right

(Include pregnancy within 3 months of death)

Major findings of operation: — Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work? N/M

23. SIGNATURE: A.M. Balter

A.M. BALTER, LT. COL., M.C. CLIN. DIR.

Address: Ft. Howard, Md. Date signed: 11-17-45

115 W St Augustine Blvd

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

138

10860

CERTIFICATE OF DEATH

Reg. Dist. No. 9 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Towson, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since November 13, 1942
Hospital, Institution, or street address where death occurred:
Eudowood Sanatorium, Towson, 4 Md.
How long in hospital or institution? Since Nov. 13, 1942

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County A A County
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. Maryland Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Elizabeth Purdy

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Wm Purdy
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 20, 1872

8. AGE: Years	Months	Days	If less than one day
73	1		..... hrs. ..... min.

9. Birthplace AA. County Md
(Town, county, and state)
10. Usual occupation Housewife Work
11. Industry or business
FATHER 12. Name Joseph Ford
13. Birthplace Maryland
MOTHER 14. Maiden name Mary Ann Gardner
15. Birthplace Maryland
16. Informant Personal History-Hospital records
Address Eudowood Sanatorium, Towson 4, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 2/45 (month) (day) (year)
Cemetery or crematory Cedar Neuk
Location Annapolis, Md
18. Funeral director B. L. Hopping
Address Annapolis Md
19. Nov. 29 1945 (Date rec'd by registrar) Howard Hartman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1945 at 11:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 13 1942 to Nov 29 1945 and that I last saw h.. alive on November 29 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Onset in 1937
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE William A. Bridges M. D. or other
Address Towson 4 Maryland Date signed 11-29-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10861

Reg. Dist. No. 9-38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since February 9, 1945
Hospital, Institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution? Since February 9, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Rising Sun
(If outside city or town limits, write RURAL and give nearest town)
Street No.: South Queen St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ruth R Reed

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Ralph M Reed
6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): 7- -1909

8. AGE: Years	Months	Days	If less than one day
36	4		hrs. min.

9. Birthplace: Harford County Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Harry Rayburn
13. Birthplace: Havre de Grace, Md

MOTHER
14. Maiden name: Minnie Saunders
15. Birthplace: Havre de Grace Md

16. Informant: Personal History Hospital Records
Address: Eudowood Sanatorium Towson 4, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 9 45 (month) (day) (year)
Cemetery or crematory: Rose Bank Cemetery
Location: Calvert Md
18. Funeral director: W. M. Pippin & Son
Address: Elkton Md Per W. A. Gundry
19. Nov 6 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 6 1945, at 11:25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 9 1945, to Nov 6 1945
and that I last saw her alive on 1945

Immediate cause of death: Pulmonary Tuberculosis — Duration: Dec 1944
Due to: Hemorrhage — Duration: 10 yrs.
Due to: ago
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: William A Bridges M. D. or other
Address: Towson 4 Maryland Date signed:

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73A)

CERTIFICATE OF DEATH

10862

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
530 Park Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 530 Park Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MARY F. REICHART

3.(b) Social Security Number: **

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Henry F. Reichart
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 16, 1867

8. AGE: Years	Months	Days	If less than one day
78	6	28	hrs. min.

9. Birthplace: Balto. Co., Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Joseph Winkler
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. Harry B. C. Green
Address: 530 Park Ave., Towson, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof Nov. 17, 1945 (month) (day) (year)
Cemetery or crematory: St. Josephs
Location: Fullerton, Md.

16. Funeral director: Lannahan Funeral Home
Address: 7401 Belair Road

19. 11/16/1945 (Date rec'd by registrar) A. M. Bacon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 14th 1945 at 7:30P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3/27/1941 to 11/14/1945 and that I last saw h[illegible] alive on 11-14 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	5 minutes
Due to: Arteriosclerosis	4 yrs +
Due to: arterial hypertension	"
Due to:	
Other conditions: Senility	
Myocardial Degeneration	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Jas. W. Macken M.D.
M. D. or other
Address: 6504 Belair Rd Date signed 11/15/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

10863

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 0 yrs., 0 mos., 5 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 0 yrs., 0 mos., 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 227 S. Castle Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Angelo Reyes

3.(b) Social Security Number: 433-24-7710

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 2, 1889 (?)

8. AGE: Years	Months	Days	If less than one day
56	3	4	hrs. min.

9. Birthplace: Puerto Rico (Town, county, and state)

10. Usual occupation: Steward

11. Industry or business:

FATHER
12. Name: Angelo Reyes
13. Birthplace: Puerto Rico

MOTHER
14. Maiden name: Dolores Riveras
15. Birthplace: Puerto Rico

16. Informant: Angelo Reyes
Address: 227 S. Castle St., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 8, 1945 (month) (day) (year)
Cemetery or crematory: St. John's Cemetery
Location: Ellicott City, Maryland

18. Funeral director: Lilly & Zeiler
Address: 1901-07 Eastern Ave., Balto., Md.

19. Nov. 6, 1945 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 6, 1945, at 9:25 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 1, 1945 to November 6 1945
and that I last saw h... im alive on November 6, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	15 Mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: Mitral Stenosis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: No operation Date of op.:

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Stewart S. Shaffer M.D. (M.D. or other)
Address: Mount Wilson, Md. Date signed: 11/6/45

Recd by Dr E E Nichols 11-9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of name of county where death occurred is shown on

FILM No. G 99 DEC 20 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

10864 P

Reg. Dist. No. 447 42

1. PLACE OF DEATH:
County: ~~Anne Arundel~~ Baltimore
City or town: Lansdowne
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ~~Anne Arundel~~ Baltimore
City or town: Lansdowne
(If outside city or town limits, write RURAL and give nearest town)
Street No. 211 Hazel Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mildred M. Ringrose

3.(b) Social Security Number: 215-12-0557

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John A. Ringrose
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): September 13, 1900

8. AGE: Years	Months	Days	If less than one day
45	1	26	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Charles W. Boecker
13. Birthplace: Maryland
MOTHER 14. Maiden name: Ifreda Boecker Fenker
15. Birthplace: Germany
16. Informant: George Boecker
Address: 211 Hazel Ave. Lansdowne
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-17-45 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore Md.
18. Funeral director: George L. Schwab
Address: 2101 Frederick Avenue
19. Nov 9 1945 (Date rec'd by registrar) A W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 8, 1945, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 8, 1945, to November 8, 1945
and that I last saw her alive on November 8, 1945

Immediate cause of death	DURATION
Carcinoma of Breast, Lft	2 YRS
C metastasis +	
Due to: pleural effusion	
Due to:	
Other conditions:	

(Incinde pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edgar F. Mueller M.D.
M. D. or other
Address: 2623 Washington Blvd. Date signed: 11/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

2326 Miller

3031

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

10865

Reg. Dist. No. 35

1. PLACE OF DEATH:
County: Baltimore
City or town: Rural near Parkton.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 47 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: Baltimore.
City or town: Rural near Parkton.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: North of Parkton.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Nellie Pearl Rosier.

3.(b) Social Security Number: 216-03-4339.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife: Harry Rosier
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): September 7, 1898.

8. AGE:

Years	Months	Days	If less than one day
47	2	12.	...hrs. ...min.

9. Birthplace: Parkton, Md. R.D. (Town, county, and state)
10. Usual occupation: Operator.
11. Industry or business: Sewing Factory.

FATHER
12. Name: Hugh B. Hunt.
13. Birthplace: Bentley Springs, Md.

MOTHER
14. Maiden name: Leah Lavina Wilson.
15. Birthplace: Bentley Springs, Md.

16. Informant: Harry Rosier
Address: Parkton, Md. R. D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 22, 1945. (month) (day) (year)
Cemetery or crematory: Mt. Zion Cemetery
Location: Free Land, Md.

18. Funeral director: Jacob Hartenstein
Address: New Freedom, Pa.

19. Nov 20 1945 (Date rec'd by registrar) Calvin L. Fuller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 19, 1945, at 8:40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 16 - 1945, to Nov. 19 - 1945, and that I last saw him alive on Nov. 18 - 1945.

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Arteriosclerosis	
Due to: Chronic Diabetes Mellitus	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: James L. Yoagle, M. D. or other
Address: New Freedom Pa. Date signed Nov. 20-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10866

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 0 yrs., 0 mos., 5 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch Maryland Tuberculosis Sanatorium
How long in hospital or institution? 0 yrs., 0 mos., 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elk Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Nellie Ross

3.(b) Social Security Number: 212-26-2443

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 28, 1928

8. AGE: Years	Months	Days	If less than one day
17	1	5	..... hrs. ..... min.

9. Birthplace: Grant, Virginia (Town, county, and state)
10. Usual occupation: Student
11. Industry or business

FATHER
12. Name: William Ross
13. Birthplace: Grant, Virginia

MOTHER
14. Maiden name: Myrtle Rhodes
15. Birthplace: North Carolina

16. Informant: Nellie Ross
Address: Elk Mills, Cecil Co., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 6, 1945 (month) (day) (year)
Cemetery or crematory: Cherry Hill Cemetery
Location: Cecil Co., Md.

18. Funeral director: J. E. Tyson
Address: Rising Sun, Maryland

19. Nov. 2, 1945 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 2, 1945 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 28, 1945 to November 2 1945 and that I last saw her alive on November 2, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 Mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: Fatal Pleural Shock	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Stewart S. Shaffer M.D. M.D. or other
Address: Mount Wilson, Md. Date signed: 11/2/45

Rec'd 11-6-45 Dr E E Nichols

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
NOV 7 1945
U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-21)

10867

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Villa Nova
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Robb Nursing Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3301 Guilford avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: NO

3.(a) FULL NAME: ELIZABETH URBAN RUSSELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Charles I. Russell
6.(c) If alive, give age: ——— years
7. Birth date of deceased (mo., day, yr.): April 23, 1888

8. AGE: Years	Months	Days	If less than one day
57	6	15	...hrs. ...min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: At home
11. Industry or business

FATHER
12. Name: John Urban
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: Germany

16. Informant: Miss Margaret Russell
Address: 3301 Guilford avenue

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 12, 1945 (month) (day) (year)
Cemetery or crematory: Moreland Memorial Park
Location:

18. Funeral director: Chas. E. Evans & Son Inc.
Address: 118 N. Mt. Royal Ave.

19. 11-9- 19 45 E. E. Nichols Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 8 1945, at 1245 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 7 1945, to Nov 8 1945, and that I last saw h.. alive on Nov 8 1945.

	DURATION
Immediate cause of death: Cerebral Hemorrhage (b) antecedent	24 hr.
Due to: Arterio Sclerosis	?
Due to: Arterial Hypertension	?
Other conditions	

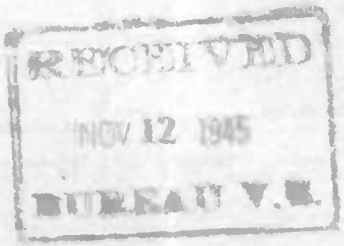
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. E. Nichols M.D.
M. D. or other
Address: Pikesville 8 Md. Date signed: 11-9-45

Dr. E.E. Nichols
1402 Reisterstown, road



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10868

Reg. Dist. No. 42

1. PLACE OF DEATH:

County: Baltimore

City or town: Lansdowne (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 617 Bush ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Lansdowne (If outside city or town limits, write RURAL and give nearest town)

Street No. 617 Washington Ave (If rural, give LOCATION)

2.(a) If veteran, name war: WWII

3.(a) FULL NAME John C Scanlon

3.(b) Social Security Number 219-07-5560

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Louise M Scanlon

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 1-1887

8. AGE: Years: 57 | Months: 11 | Days: 25 | If less than one day: ....hrs. ....min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: Sheet Metal Worker

11. Industry or business

FATHER — 12. Name: Timothy Scanlon

FATHER — 13. Birthplace: Baltimore Co Md

MOTHER — 14. Maiden name: Emma Cushing

MOTHER — 15. Birthplace: Baltimore Co Md

16. Informant: Mrs Emma Scanlon

Address: 3304 Georgetown Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/28/45 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Pikesville Md

18. Funeral director: Millhouse & Joe

Address: 1242 E Fayette St

19. Nov 27 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 26 1945, at 6-15 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ....19.... to ....19....

and that I last saw h... alive on ....19....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to, Sudden death	
Other conditions	
Injury	

(Include pregnancy within 3 months of death)

Major findings of operation: ....Date of op....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Geo M Kieffer Dept Med & Surg John Hopkins M. D. or other

Address: 1010 Linden Ave Date signed 11-26-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

10869

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Balto. Co.

City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 104 Locust Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Frederick B. Schaefer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary D. Wortham

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1866

8. AGE: Years	Months	Days	If less than one day
79	2	17	..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Jacob Schaefer

13. Birthplace Germany

MOTHER 14. Maiden name Minnie Bauer

15. Birthplace Germany

16. Informant Mrs. Mary D. Schaefer

Address 104 Locust Drive

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-26-45 (month) (day) (year)

Cemetery or crematory London Park

Location Baltimore

18. Funeral director Forrest Byers

Address 5005 Park Heights Ave.

19. 11/25 19 45 Harvey W. Miller
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 19 45 at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 22 19 25 to Nov. 23 19 45.

and that I last saw h... alive on Nov. 22 19 45

	DURATION
Immediate cause of death Uraemia	4 days
Due to Chr. Nephritis	6 Mos.
Due to	
Other conditions Gastric Ulcer	25 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation 0 Date of op.

Autopsy results 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide 0 Date of

Where did injury occur? 0 (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury 0 Injured at work?

23. SIGNATURE S. Lloyd Johnson M.D.
M. D. or other

Address Catonsville, Md. Date signed 11/23/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

10 magnifier Re. Miller.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10870 30

Reg. Dist. No. 194

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 303 Hurstland Lane
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Elizabeth Schaub

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife John H Schaub
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Sept. 13, 1883

8. AGE: Years	Months	Days	If less than one day
62	1	28	..... hrs. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual occupation at home
11. Industry or business
FATHER 12. Name Joseph Salmon
13. Birthplace Md
MOTHER 14. Maiden name Pauline Hayes
15. Birthplace Md.
16. Informant John H Schaub
Address Catonsville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-13-45 (month) (day) (year)
Cemetery or crematory Woodlawn
Location Woodlawn Md
18. Funeral director F.C. Higinbothom
Address Ellicott City Md
19. Nov. 13, 1945 (Date rec'd by registrar) John B. Lynch Asst. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11 1945 at 3 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 6 1944 to November 10 1945 and that I last saw h[illegible] alive on Nov. 10 1945

Immediate cause of death	DURATION
Myocardial Insufficiency	1 Yr.
Due to Hypertension	?
Due to Generalized arterio-sclerosis	?
Other conditions Senile dementia	13 yr.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wilmer K. Gallagher M.D. M. D. or other
Address Catonsville-28, Md Date signed 11-12-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

10871

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH

County: Balto

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County:

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Harlem ave + Maryland ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Catherine C. Schier

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Everett R. Schier

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): May 30, 1891

8. AGE: Years	Months	Days	If less than one day
54	5	4	....hrs. ....min.

9. Birthplace: Baltimore

(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER — 12. Name: Daniel Eleighter

13. Birthplace: Baltimore

MOTHER — 14. Maiden name: Adelaide Reid

15. Birthplace: Maryland

16. Informant: Mrs D Burgin

Address: 1601 Montpelier St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 6, 1946 (month) (day) (year)

Cemetery or crematory: Baltimore

Location: East North ave

16. Funeral director: S. Walter May

Address: 619 N. Bouldin St. #5

19. 11/5 19 45 (Date rec'd by registrar) J Carroll Mongomery E.E. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 3, 1945, at 12.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 9 1940, to November 3 1945 and that I last saw h.er alive on November 3 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 da.
Due to Adenocarcinoma of Endometrium	?
Due to Diabetes	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wilmer K. Fallager M.D. M. D. or other

Address: Catonsville 6.28.Md Date signed 11-5-45

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VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10872

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: 115 Melrose Ave., Catonsville Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 115 Melrose Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Mary Elizabeth Sheppard

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John W. Sheppard

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 22, 1869

8. AGE: Years	Months	Days	If less than one day
76	9	28	..... hrs. ..... min.

9. Birthplace: Howard Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Augustus Gover

FATHER 13. Birthplace: Howard Co. Md.

MOTHER 14. Maiden name: Sarah Harvey

MOTHER 15. Birthplace: Maryland

16. Informant: Harvey E. Shepherd

Address: 115 Melrose Ave. Catonsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 23, 1945 (month) (day) (year)

Cemetery or crematory: Mt. View Cem.

Location: Slacks Corner, Md.

18. Funeral director: Easton Sons

Address: 608 Frederick Ave. Catons.

19. 11/22 1945 Harvey W. Miller
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 20, 1945, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 15 1945 to Nov. 20 1945

and that I last saw h.. alive on Nov. 20 1945

Immediate cause of death	DURATION
Hypertensive cardiovascular disease	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Ira A. Robinson M.D.
M. D. or other

Address: Ellicott City Md. Date signed 11/20/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-C

CERTIFICATE OF DEATH

10873

Reg. Dist. No. .....

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, Institution, or street address where death occurred:

14 Westley Ave.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 14 Westley Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME AUGUSTUS SMITH

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

B.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 1, 1862

8. AGE: Years	Months	Days	If less than one day
83	6	25	..... hrs. ..... min.

9. Birthplace Howard Co., Md.

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Charles Smith

13. Birthplace Md.

MOTHER 14. Maiden name Joeanna Guff

15. Birthplace Md.

16. Informant Mrs. Joeanna Smith

Address 18 Westley Ave.

17. Burial Date thereof Nov. 29, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bushy Park Cem.

Location Cooksville, Howard Co., Md.

18. Funeral director Mrs. Frances A. Hemsley

Address 578 W. Biddle St.

19. 11/28 1945 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 1945 at 7 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 12 1945 to Nov 26 1945

and that I last saw h alive on Nov. 26 1945

Immediate cause of death

1. Mitral Insufficiency ?

Due to

2. Arterio-Sclerosis

Due to .....

Other conditions —

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE L. F. Maloney M. D. or other

Address Catonsville Md. Date signed 11/28/45

26

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

10874

CERTIFICATE OF DEATH

Reg. Dist. No. 3d

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred: Spring Grove State Hospital, Catonsville, Md
How long in hospital or institution? 4 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ~~506~~ Md County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 506 Stevenson Lane
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Ida Phinea Smith

3.(b) Social Security Number

4. Sex Female
5. Color or race White
6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Oscar Smith died 1917
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) July 7, 1865

8. AGE: Years 80 Months 4 Days 18 If less than one day ... hrs. ... min.

9. Birthplace Ulster Co. N. York (Town, county, and state)
10. Usual occupation House wife
11. Industry or business —

FATHER
12. Name Christopher ?
13. Birthplace N. York

MOTHER
14. Maiden name Delany Embrey ?
15. Birthplace ?

16. Informant Howard Beaumont
Address 506 Stevenson Lane, Balto

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 11/26/45 (month) (day) (year)
Cemetery or crematory Loudon Park
Location Balto City Md.
18. Funeral director Edgar S. MacNabb
Address Catonsville Md
19. 11/26 19 45 Harvey W. Miller
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 19 45, at 6:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death: Acute cardiac failure

DURATION

Due to

Due to Cardio vascular disease

Other conditions: sudden death Inquiry
(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE Geo. S. McKieffer Dep. Med. Exam. of Balto
M. D. or other
Address 1010 Leeds ave Date signed 11-25-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

10875

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville 28
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month 19 days
Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 1 month 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If ontside city or town limits, write RURAL and give nearest town)
Street No. 734 Bond Street
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Harvey Snell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Christina Shaw
6.(c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) October 6, 1896

8. AGE: Years	Months	Days	If less than one day
49	1	24	....hrs. ....min.

9. Birthplace Dunnellen, New Jersey (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name Napoleon Snell
13. Birthplace Lincoln Ill.

MOTHER
14. Maiden name Mary Waldron
15. Birthplace Plainfield, New Jersey

16. Informant Hospital Records
Address Catonsville, 28 Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 3 (month) 1946 (day) (year)
Cemetery or crematory Spring Grove State Hosp.
Location Catonsville 28 Md.
18. Funeral director Spring Grove St. Hosp.
Address Catonsville 28 md

19. 1/2/46 (Date rec'd by registrar) 1945 Harry J. Mullen Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30, 1945, at 6:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 11, 1945, to November 30 1945 and that I last saw him alive on November 30, 1945

Immediate cause of death	DURATION
Myocarditis, Acute	5 days
Due to Broncho-Pneumonia, Bilateral	5 days
Due to	
Other conditions Tuberculosis, both upper lobes. Chronic.	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Isadore Turk, M.D. M. D. or other
Address Spring Grove State Hosp. Date signed Dec 2, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (4) Reg. Dist. No. 4 4

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Baltimore
(b) City or town Essex, Md. (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 607 Delaware Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 6 mos.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 607 Delaware Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** Clark Edgar Stahl

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Widower

6 (b) Name of ~~husband~~ or wife Kathryn E. Stahl
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1871

8. AGE: Years	Months	Days	If less than one day
74	5	17	hr. min.

9. Birthplace Somerset, Pa. (Town, county, and state)
10. Usual occupation Butcher
11. Industry or business —

FATHER
12. Name William Stahl
13. Birthplace Somerset Pa

MOTHER
14. Maiden Name Kathryn Earnest
15. Birthplace Stahlstown Pa

16 (a) Informant W. Earnest Stahl
(b) Address 600 Spring St. Latrobe Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3, 1945 (month) (day) (year)
(c) Cemetery or crematory Unity Cem.
Location Latrobe, Pa

18 (a) Funeral director Durward D. Covington
(b) Address 21 W. 25th St.

19 (a) Dec. 1 1945 (Date rec'd by registrar) (b) John S. Connelly Registrar

MEDICAL CERTIFICATION

20. Date of death Nov 30 1945, at 9:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945, to Nov 30 1945, and that I last saw him alive on Nov 30 1945.

Immediate cause of death	Duration
Coronary Thrombosis	Sudden
Due to Arteriosclerotic Cardiovascular disease	
Due to	
Other conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D. or other
Address Balto 6 Date signed 11/30/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

ADDITIONS ON CERTIFICATE: NEW CER. FILED BY DR. ABRAMOVITZ filmed 12-7-45 G. 99 LL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 108774

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Veterans Hospital

How long in hospital or institution? 12 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Balto.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 607 Madeira St.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I ✓

3.(a) FULL NAME Robert STANTON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	Married

6.(b) Name of husband or wife: Ruth Stanton

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): 11/24/45 8-1-1898

8. AGE:

Years	Months	Days	If less than one day
11/24/45 47	3	23	...hrs. ...min.

9. Birthplace: Culpeper, Va.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farming

FATHER
12. Name: Robt Stanton
13. Birthplace: Culpeper Va

MOTHER
14. Maiden name: Lillie Stanton
15. Birthplace: Culpeper, Va.

16. Informant: M. M. Nash, Supt. ALSO: Clinical records, Vets. Adm. Hospital, Fort H...
Address: Culpeper, Va.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 11/24/45 (month) (day) (year)

Cemetery or crematory: Fairview Cemetery

Location: Culpeper Va.

18. Funeral director: Randolph G. Locke

Address: 1304 N. Central Ave

19. 11/24 (Date rec'd by registrar) 19 45 Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/24/45 19... at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 31, 1945 19... to Nov. mber 24 1945 and that I last saw h.m alivo on 11/24/45 19...

Immediate cause of death	DURATION
Hypertensive and Coronary Arteriosclerotic heart disease	9 mos.
Due to	
Due to	
Other conditions: Nephrosclerosis with Chronic uremia, Terminal bronchopneumonia (include pregnancy within 3 months of death)	

Major findings of operations: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Leonard J. Abramovitz, Capt. M.C. (M. D. or other)

Address: Veterans Hospital, Fort Howard, Md. Date signed 11/24/45

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

Reg. Dist. No. 10878 44

P

1. PLACE OF DEATH:
County Balto Co.
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No. 409 Woodbine Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Aloma M. Staples.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Elizabeth D. Staples
6.(c) If alive, give age 50 years
7. Birth date of deceased (mo., day, yr.) Oct 13 - 1895

8. AGE: Years	Months	Days	If less than one day
50	1	1	hrs. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual occupation Steel worker
11. Industry or business
FATHER 12. Name Andrew F. Staples
13. Birthplace Va
MOTHER 14. Maiden name Francis Via
15. Birthplace Via
16. Informant Mrs Elizabeth D. Staples
Address 409 A Woodbine ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 17 (month) (day) (year)
Cemetery or crematory Oak Lawn Cem
Location City
18. Funeral director Ulrich Funeral Home
Address 2005 Orleans St
19. 11/15 19 45 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14th 1945 at 11 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 1945 to Nov. 14 1945 and that I last saw h— alive on Nov. 14, 1945

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Andrew Kurowski MD
M. D. or other
Address 2579 Eastern Av. Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10879

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Balto
City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs
Hospital, Institution, or street address where death occurred: Augsburg Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Campfield Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Agnes Stehli

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Single

B.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 24, 1862

8. AGE:

Years	Months	Days	If less than one day
83	1	17	hrs. min.

9. Birthplace: Balto Md
(Town, county, and state)
10. Usual occupation: None
11. Industry or business:

FATHER
12. Name: Anthony Stehli
13. Birthplace: France

MOTHER
14. Maiden name: Kunigunda Wendel
15. Birthplace: ?

16. Informant: Records
Address: Augsburg Home

17. Burial, cremation, or removal. Which?: Burial
Date thereof: Nov 13. 45 (month) (day) (year)
Cemetery or crematory: Balto Cem
Location: North Ave.

18. Funeral director: L. HECKMANN & SON
Address: 32 S. BROADWAY.

19. Nov. 12 19 45 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 11th. 19 45 at 3 15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 7th. 19 45 to Nov. 11 19 45
and that I last saw her alive on Nov. 10th. 19 45

Immediate cause of death	DURATION
1) - Arterio - Sclerotic Heart Disease	2 yrs.
Due to	
Due to	
Other conditions - Acute Cardiac Failure (Incinde pregnancy within 3 months of death)	2 hours

Major findings of operation: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Earl L. Chambers M. D. or other
Address: 108 Liberty Hts. Date signed: 11/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-2)

10880

CERTIFICATE OF DEATH

Reg. Diat. No. 33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 yrs

Hospital, Institution, or street address where death occurred: Reisterstown Rd nr Cherry Hill Rd

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Reisterstown Rd nr Cherry Hill Rd

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: Alma Louise Stocksdale

3. (b) Social Security Number: NO

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: Arthur L Stocksdale

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): March 23 1892

8. AGE: Years: 53 | Months: 8 | Days: 4 | If less than one day: ...hrs. ...min.

9. Birthplace: Scranton Pa

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: -

FATHER 12. Name: Frank Rauschmieur

13. Birthplace: Unknown

MOTHER 14. Maiden name: Alma Oilman

15. Birthplace: Unknown

16. Informant: Arthur L. Stocksdale

Address: Reisterstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 30 1945 (month) (day) (year)

Cemetery or crematory: Asbury Cemetery

Location: Reisterstown Md

19. Funeral director: Wm Berryman & Sons

Address: Reisterstown Md

19. Nov. 30 1945 (Date rec'd by registrar) Mary B. Ehrie Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 27 1945 at 9P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1 1945 to 11-27 1945

and that I last saw h[illegible] alive on 11-27-45 1945

Immediate cause of death	DURATION
Carcinoma of uterus	2 yrs
Due to: Cachexia	1 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: - Injured at work?

23. SIGNATURE: James L. Lafell M. D. or other

Address: Reisterstown Md Date signed: 11/29/45


DEC 3 1945
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-a)

CERTIFICATE OF DEATH

10881 P

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Edgemere Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Edgemere
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3114 Lynch Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Frank A Stone

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary E Stone
6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): Sept 17th 1880

8. AGE: Years	Months	Days	If less than one day
65	2	3	hrs. min.

9. Birthplace: Coatesville Pa (Town, county, and state)
10. Usual occupation: Steel Mill
11. Industry or business: Heater
FATHER 12. Name: David Stone
13. Birthplace: Wilmington Pa
MOTHER 14. Maiden name: Emma Lamborn
15. Birthplace: Lancaster Pa
16. Informant: Mary E Stone
Address: 3114 Lynch Road
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Nov 24th (month) (day) (year)
Cemetery or crematory: Pine ME Cemetery
Location: Coatesville Pa
18. Funeral director: Ulrich Funeral Home
Address: 2104 Orleans St
19. Nov 23 19 44 (Date rec'd by registrar) C W Heyde asst Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 20th 19 44 at 5 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 17 1945 to Nov 20 1945 and that I last saw him alive on Nov 10 1945

Immediate cause of death: Coronary Thrombosis - arterio - sclerosis -
Due to: Chronic Myocarditis
Due to:
Other conditions: Chronic Nephritis secondary to heart -
(Include pregnancy within 3 months of death)

DURATION: Past

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Louis H. Krummeni M. D. or other
Address: 722 N. Kenwood Ave Date signed: 11/22/44

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

10882

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Baltimore
City or town: Randallstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Liberty Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Randallstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Liberty Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Oliver L. Sullivan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 31, 1885

8. AGE:	Years	Months	Days	If less than one day
	60	9	28	..... hrs. ..... min.

9. Birthplace: Baltimore County, Md.
(Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business
FATHER 12. Name: William T. Sullivan
13. Birthplace: Baltimore County, Md.
MOTHER 14. Maiden name: Margaret Heaps
15. Birthplace: Baltimore County, Md.
16. Informant: Mrs. Philip Krider
Address: Liberty Road, Randallstown
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 30, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Olive Cemetery
Location: Randallstown, Md.
18. Funeral director: Willis Funeral
Address: 4510 Liberty Heights Ave.
19. 11/28/45 (Date rec'd by registrar) Mrs. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 28 1945 at 10.20A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 to Nov. 28, 1945
and that I last saw him alive on Nov. 28, 1945

Immediate cause of death	DURATION
Coronary occlusion	1 hour
Due to Arteriosclerosis	
Due to	
Other conditions Myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Mrs. E. Martin M. D. or other
Address: Harrisonville, Md. Date signed 11/28/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55-2

CERTIFICATE OF DEATH

10883 44

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Maryland

How long in hospital or institution? 55 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County .....

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 709 Fremont Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME JAMES R. TAYLOR

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Ruby Taylor

6.(c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) 3-20-1892

8. AGE: Years	Months	Days	If less than one day
53	7	28	..... hrs. ..... min.

9. Birthplace Crewe, Va.
(Town, county, and state)

10. Usual occupation Carbon Worker

11. Industry or business

FATHER 12. Name Edward Taylor

FATHER 13. Birthplace Virginia

MOTHER 14. Maiden name Mary Farror

MOTHER 15. Birthplace Virginia

16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-23-45 (month) (day) (year)

Cemetery or crematory BALTIMORE NATIONAL CEMETERY

Location BALTIMORE MD

18. Funeral director William A Jackson

Address 916 Penna ave Baltimore Md

19. 11/21/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18, 1945, at 9:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 24, 1945, to November 18, 1945 and that I last saw him alive on November 18, 1945

Immediate cause of death	DURATION
Generalized Carcinomatosis of abdomen	4 Mos. plus
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE A.M. Balter

Address A.M. BALTER, LT. COL., M.C., M. CLIN. DIR. Ft. Howard, Md. Date signed 11-19-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (27)

16884

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County THE SHEPPARD & ENOCH PRATT HOSPITAL

City or town TOWSON MD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days.

Hospital, institution, or street address where death occurred:

Same

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County .....

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 112 E. Lake Avenue.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Laura Fulton Taylor

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife B. Conway Taylor 6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) August 24, 1891

8. AGE: Years	Months	Days	If less than one day
54	3	1	..... hrs. ..... min.

9. Birthplace Salisbury, Wicomico, Maryland (Town, county, and state)

10. Usual occupation Housewife.

11. Industry or business

FATHER 12. Name John S. Fulton

13. Birthplace Ohio

MOTHER 14. Maiden name Nancy Ellen White

15. Birthplace Maryland.

16. Informant Hospital Records

Address .....

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/28/45 (month) (day) (year)

Cemetery or crematory Parsons

Location Salisbury Md.

18. Funeral director Harry H. Wittke

Address 410 E. Edmondson Ave.

19. 11/27 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 19 45, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 20 19 45 to November 25 19 45

and that I last saw h.... alive on November 25 19 45

Immediate cause of death	DURATION
Pulmonary edema;	
bronchial pneumonia	12 hrs.
Due to Myocardial failure	5 days.
Due to	
Other conditions Uremia;	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results Pulmonary edema; bronchial pneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Arthur E. Pattrell

Arthur E. Pattrell, M.D. M. D. or other

Address Sheppard-Pratt Hospital Date signed .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74

10885

CERTIFICATE OF DEATH

Reg. Dist. No. 35-

1. PLACE OF DEATH:
County Baltimore
City or town Parkton.-
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 48 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore.
City or town Parkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Amelia Mildred Tracey.-

3. (b) Social Security Number 218-18-5904.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow.

6.(b) Name of husband or wife John T. Tracey.
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.) July 5, 1897.

8. AGE:

Years	Months	Days	If less than one day
48	3	29	____ hrs. ____ min.

9. Birthplace Parkton, Md. R.D.- (Town, county, and state)
10. Usual occupation Sales lady
11. Industry or business Store.

FATHER
12. Name Adam Paff
13. Birthplace Germany.

MOTHER
14. Maiden name Belinda Tracey.
15. Birthplace Parkton, Md. R.D.-

16. Informant Mrs. Virginia Corbin.
Address Cockeysville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof November 7, 1945 (month) (day) (year)
Cemetery ~~or crematory~~ West Liberty
Location White Hall, Md. R.D.
18. Funeral director Jacob Hartenstein
Address New Freedom, Pa.
19. Nov 5 1945 (Date rec'd by registrar) Edwin L. Feaser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 1945 at 1:00 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 4 1945 to Nov. 4 1945
and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. M. France M. D. or other
Address Parkton, Md. Date signed 11/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-d)

10886

CERTIFICATE OF DEATH

Reg. Dist. No. 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 315 Ingleside Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: Ellicott City (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lillian F Turner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: Edward Turner

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Apr. 19, 1895

8. AGE:	Years	Months	Days	If less than one day
	50	7	11	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: At home

11. Industry or business

FATHER — 12. Name: Wm Yeardley

FATHER — 13. Birthplace: Md

MOTHER — 14. Maiden name: Alice Turner

MOTHER — 15. Birthplace: Md

18. Informant: W. Carter Long, Jr.

Address: Ellicott City Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-3-45 (month) (day) (year)

Cemetery or crematory: Grace Church

Location: Elkridge, Md

18. Funeral director: J.C. Higinbotham

Address: Ellicott City Md.

19. 12-1- (Date rec'd by registrar) 1945 Harry K. Mullen Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 30 1945 at 7.4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 28 1945, to Nov 30 1945

and that I last saw h.er alive on Nov. 30 1945

Immediate cause of death	DURATION
Hypertension & Cardiac vascular disease	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Jos. A. Kirkpatrick M. D. or other

Address: Ellicott City Md Date signed 12/1/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

P 10887 3D

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: near Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, Institution, or street address where death occurred: at home

How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: near Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4703 Wilkens Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME William John Weil

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Magdalena Weil

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): January-16-1880

8. AGE:

Years	Months	Days	If less than one day
65	9	28	...hrs. ...min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: (retail-meats)

FATHER

12. Name: Louis Weil

13. Birthplace: Germany

MOTHER

14. Maiden name: Christina Fogel

15. Birthplace: Germany

16. Informant: Mrs. Magdalena Weil (wife)

Address: 4703 Wilkens Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 16 45 (month) (day) (year)

Cemetery or crematory: Westlawn

Location: Baltimore City

19. Funeral director: Stewart & Mowsen Company

Address: 108 W. North Ave.

19. 11-16 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 13 1945 at 10:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1943 to November 13 1945 and that I last saw h. alive on November 13 1945

	DURATION
Immediate cause of death: Cardio Vascular Degeneration & heart failure	3 years
Due to:	
Due to:	
Other conditions: Multiple Emboli Uremia (Include pregnancy within 3 months of death)	11 wks Louis

Major findings of operation: Empyema Left (Thoracotomy) Date of op. April 1945

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Earl Pass M.D. (M. D. or other)

Address: 400 Wilkens Ave Date signed: 11-14-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10888

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 89 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 89 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 28 E. Mt. Vernon Place
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: GORDON T. WHELTON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Divorced

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 10-18-1881

8. AGE:	Years	Months	Days	If less than one day
	64	0	26	hrs. min.

9. Birthplace: Crisfield, Md.
(Town, county, and state)

10. Usual occupation: Civil Engineer

11. Industry or business

FATHER — 12. Name: Thomas Whelton
13. Birthplace: Maryland

MOTHER — 14. Maiden name: Missouri Carmine
15. Birthplace: Virginia

16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 17 1945 (month) (day) (year)

Cemetery or crematory: Baltimore Memorial

Location: Furnish Road

18. Funeral director: Oden Funeral Home Inc.

Address: 4644 York Rd

19. 11-16 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 14, 1945 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 17, 1945, to November 14, 1945 and that I last saw him alive on November 14, 1945

Immediate cause of death	DURATION
Acute, Cystitis, Suppurative	
Due to Pyelitis, chronic bilateral	
Due to Prostatic hypertrophy, benign	
Other conditions Pneumonia, Broncho	
Cholecystitis with lithiasis chronic	

(Include pregnancy within 3 months of death)

Major findings of operations: Herniaplasty Right 9-13-45
Herniaplasty left Date of op. 10-15-45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A. M. Balter
A. M. BALTER, LT. COL., M.C., CLIN. DIR.

Address: Ft. Howard, Maryland Date signed: 11-15-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

10889 P

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: BALTO. CO.
County Fort Howard
City or town Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Veterans Administration
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto.
City or town Balto.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Hanford Road - Cub Hill
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Lee Wright

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Estelle M.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 4 - 1890

8. AGE: Years	Months	Days	If less than one day
55	—	20	..... hrs. ..... min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual occupation Conveyor Boyer
11. Industry or business

FATHER
12. Name Oliver B. Wright
13. Birthplace Md.

MOTHER
14. Maiden name Ella J. Reary
15. Birthplace Md.

16. Informant Mrs. Estella M. Wright
Address Hanford Rd - Cub Hill

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11 - 28 - 45 (month) (day) (year)
Cemetery or crematory Balto. National
Location Balto.

18. Funeral director Leonard J. Luck
Address 5305 Hanford Rd.

19. 11/26 1945 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1945 at 8:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/24 1945 to 11/24 1945 and that I last saw him alive on 11/24 1945

Immediate cause of death	DURATION
Hypertensive and coronary Arteriosclerotic heart disease	
Due to	
Due to	
Other conditions Nephrosclerosis with uremia	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Leonard J. Abramitis, Capt MC M. D. or Other
Address Veterans Hospital Fort Howard Md. Date signed 11/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (526)

CERTIFICATE OF DEATH

10890 38

Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Lutherville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 1/2 yrs
Hospital, institution, or street address where death occurred:
Home Seminary Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Lutherville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Seminary Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME Robert Wilson

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anne Elizabeth Wilson (nee Schofield) 6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.): Nov 9, 1870.

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
75		15		

9. Birthplace: England (Town, county, and state)
10. Usual occupation: Marine Engineer
11. Industry or business: Oil Business
FATHER 12. Name: James Hastings Wilson
13. Birthplace: Scotland
MOTHER 14. Maiden name: Anne Whittle
15. Birthplace: England
16. Informant: Mrs. Anne Elizabeth
Address: Seminary Ave. Lutherville
17. 3 (Burial, cremation, or removal. Which?) Date thereof 11-26-45 (month) (day) (year)
Cemetery or crematory: Prospect Hill Cem.
Location: Lutherville Md.
18. Funeral director: James L. McCarthy
Address: 120 E. Lexington
19. Nov. 26 1945 C. W. Hedrick Registrar
(Date rec'd by registrar) A.E.S.

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 24 1945, at 5:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Heart disease, chronic myocarditis	3 yrs.
Due to: Coronary thrombosis, multiple	1942, 1943
Cerebral hemorrhage, right	1942, 1943
Due to: Arteriosclerosis & hypertension	Unknown.
Other conditions: Carcinoma of bladder (cured?)	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Rollin B. Hudson M.D. D.M.E.
M. D. or other
Address: Towson 4, Md. Date signed 11/24/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

★ 10891 Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Balto. Co. Md
City or town:
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? Harry Grossmann Sinai

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto.
City or town: Perry Hall
(If outside city or town limits, write RURAL and give nearest town)
Street No. Chapel Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Elizabeth Winkler

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Joseph A. Winkler
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): March 11th 1876

8. AGE: Years	Months	Days	If less than one day
69	7	24	hrs. min.

9. Birthplace: Balto. Co. Md (Town, county, and state)
10. Usual occupation: at home
11. Industry or business
FATHER 12. Name: John T. Coster
13. Birthplace: Holland
MOTHER 14. Maiden name: Litrina Denz
15. Birthplace: Germany
16. Informant: Mrs. ME Winkler
Address: Chapel Rd. Fullerton
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11 7 45 (month) (day) (year)
Cemetery or crematory: St. Josephs Cem.
Location: Balto. Co. Md
18. Funeral director: Lassahn Funeral Home
Address: 7401 Belair Rd.
19. 11/5 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 4th 1945 at 8 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1945 to Nov 4 1945 and that I last saw her alive on Nov 4 1945

Immediate cause of death	DURATION
Chr Myocarditis	6 mon
Due to:	
Due to: Hyper Tro[illegible] Arteriosclerosis	3 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Date signed: 11/5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 10892

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 56 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 56 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1116 Olive St.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-2

3.(a) FULL NAME: MATTHEW WRIGHT

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 5-14-1914

8. AGE: Years	Months	Days	If less than one day
31	5	17	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER 12. Name: Albert Wright

13. Birthplace: Oxford, Maryland

MOTHER 14. Maiden name: Gross

15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Fac.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11 - 5 - 45 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland

18. Funeral director: Isaiah L. Brown

Address: 108 W. Montgomery St. Balto., Md.

19. 11/5 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 1, 1945, at 4:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 6, 1945, to November 1, 1945 and that I last saw him alive on November 1, 1945

Immediate cause of death	DURATION
Tuberculosis, pulmonary, chronic, far advanced	10 Mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A. M. Balter

A. M. BALTER, LT. COL., M.C. or CLIN. DIR

Address: Fort Howard, Maryland Date signed: 11-1-45

10893

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Balto Co.
City or town: Catonsville
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Crpatty Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Nursery Lane & Edmondson Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Alonzo J. Wroten

3.(b) Social Security Number: 218-09-1239

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 2, 1860

8. AGE: Years: 85 | Months: 4 | Days: 3 | If less than one day: hrs. min.

9. Birthplace: Balto City (Town, county, and state)
10. Usual occupation: Custodian
11. Industry or business: Chamber of Commerce
FATHER 12. Name: Caleb Wroten
13. Birthplace: Md
MOTHER 14. Maiden name: Charlotte A. Woodland
15. Birthplace: Md
16. Informant: Mrs. Edna Ashby
Address: Falmouth Route 1, Stafford Va.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 9, 1945 (month) (day) (year)
Cemetery or crematory: Md Memorial Park
Location: Balto
18. Funeral director: A. Howard Evans
Address: 1400 Arlington Ave
19. (Date rec'd by registrar) 11/7 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 7, 1945 at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 2 1945 to Nov 7 1945 and that I last saw h alive on Nov 2 1945

Immediate cause of death	DURATION
Cer. Thrombosis	2 Mos
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jesse E. Mowell M. D. or other
Address: Catonsville Md Date signed: 11-7-45

5 mac-3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

10894

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Balto.
City or town Turners Station
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto
City or town Turners Station
(If outside city or town limits, write RURAL and give nearest town)
Street No. 107 Woodlawn Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Elsie Zachok

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	married

6.(b) Name of husband or wife Mike Zachok
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2 - 1901

8. AGE: Years	Months	Days	If less than one day
44	6	1	hrs. min.

9. Birthplace Penna. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden name "
15. Birthplace "

16. Informant Mike Zachok
Address Turners Station

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 6 - 45 (month) (day) (year)
Cemetery or crematory Sacred Heart
Location German Hill Rd.
18. Funeral director John J. Connelly
Address Essex, Md.

19. Nov. 6 1945 John J. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3rd 1945 at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945 to November 3rd 1945;
and that I last saw h... alive on November 3rd 1945

Immediate cause of death	DURATION
Diabetes Mellitus	5 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. N. Thomas M.D.
M. D. or other
Address 7 N. Main St. Dundalk 22 Date signed 11/5/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING